Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Dav Yaar **Physician** 1:06 P.M. MARIS BOYER MOVEMBLE STEMENON TERESA /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 000W2003 HARFORD 5. Social Sacurity Number DRIVE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign
Country) **Funeral** Days 1□ M 2MF Months Yrs. Director 194 24 0265 BOUSYLVANIA Usual Rasidance of Dacedani 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Exerciper must be notified at 1 ☐ Yas 2 No Director MARYLADO HARFORD 50GEWOOD 10f. Zip Coda 10e Street and Number 10g. Citizan of What Country? V.S.A. 1212 DRIVE TROAL 21040 Funeral 12. Was Decedant Evar In U.S. Armed Forcas? 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, 11. Marital Status Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: Baltimore. Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry BALTIMORE LOUNTY Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 12 YRS. ZYRS. SCHOOL DUS DRIVER BOARD OF IDULATION if of Heelth and Mental Hygical If Item 27 is marked other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) Be VOGEL Unknown Unknown 311012L 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) DAVIO ALAN BOYSE 15 PARKSTREET KANDOLPH VERTONT OSOBO 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata nov. 28. 1 Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) GARRISON 1 JARYLAND GARRISON FOREST 1997 22. Nama and Addrass of Facility HADEL - BELACR, P.A. 21. Signatura of Funeral Service Ligenses EVANS FUNDRAL 21050 3 NEW PORT ORIVE FOREST HILL ! Micho JARYLAND 23a. Part1. Entar the disaese, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause in each line. **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) **Examiner** Examiner the death certificate be axecuted Sequentially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Causa (Disaasa or injury that initieted events rasulting in deeth) Last and the burief Box 68760. Physician/Medical Dua to (or as a consequence of) USB BS for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yas 2 ☐ No Records, 8 falle 24a. Was an autopsy 24b. Wera autopsy findings available prior to Completed completion of cause of death? page arteusion 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital 25. Was cese referred to medical Attending Physician: Be 26. Placa of Death (Check only one) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After Natural 5 Pending Invastigation 4 Hospital or Ath.

Lours affer death.

U Director: AF 1 Yas 2 No 2 Accidant 6 Could not be determined 3 ☐ Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At homa, ferm, street, factory, offica building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completaly filled Medicai TS Certifying Physician: To the best of my knowledge, deeth occurred at the lime, date and piace, and due to the cause(s) and menner as steted.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian 29b. Signatura and titla of certifiac 29c. Licansa number 29d. Data signed (Month, Dev. Year) 1 lovember 24 1999

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219 WEST BELATIR AVE. ABERDEEN, MARYLAND

Registrar

State

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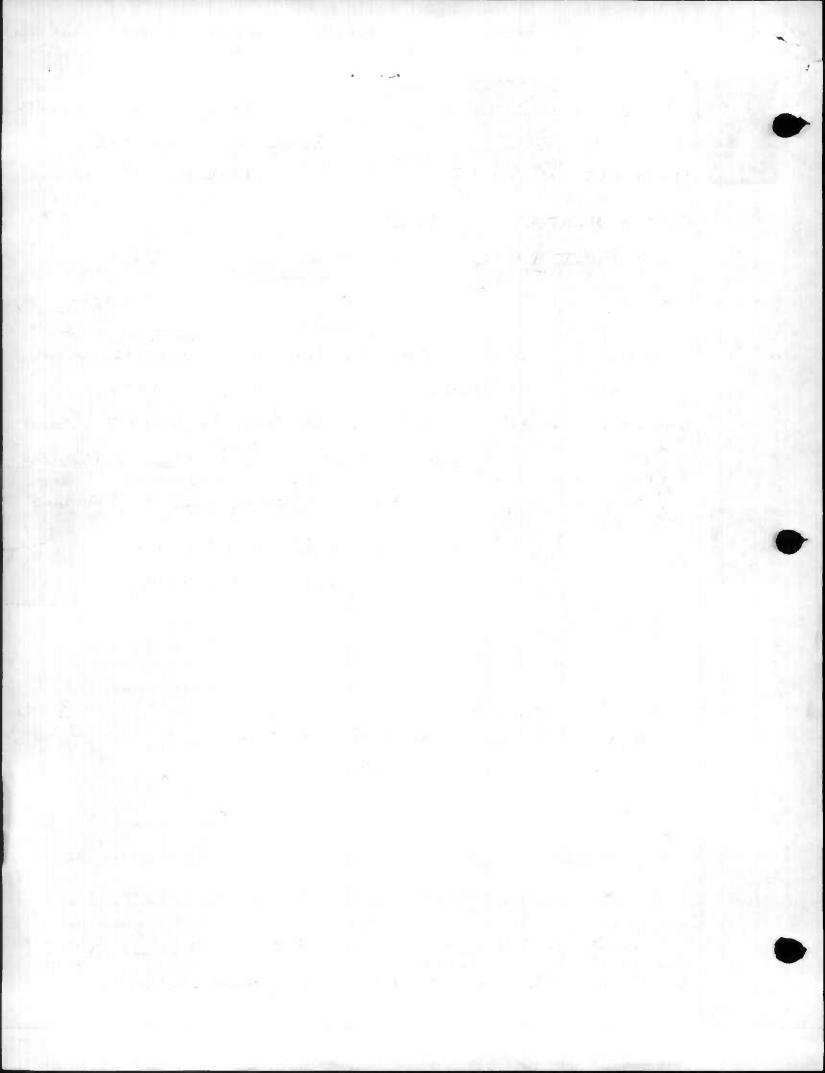
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32. Registrar a Signature
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DR. HONG J.

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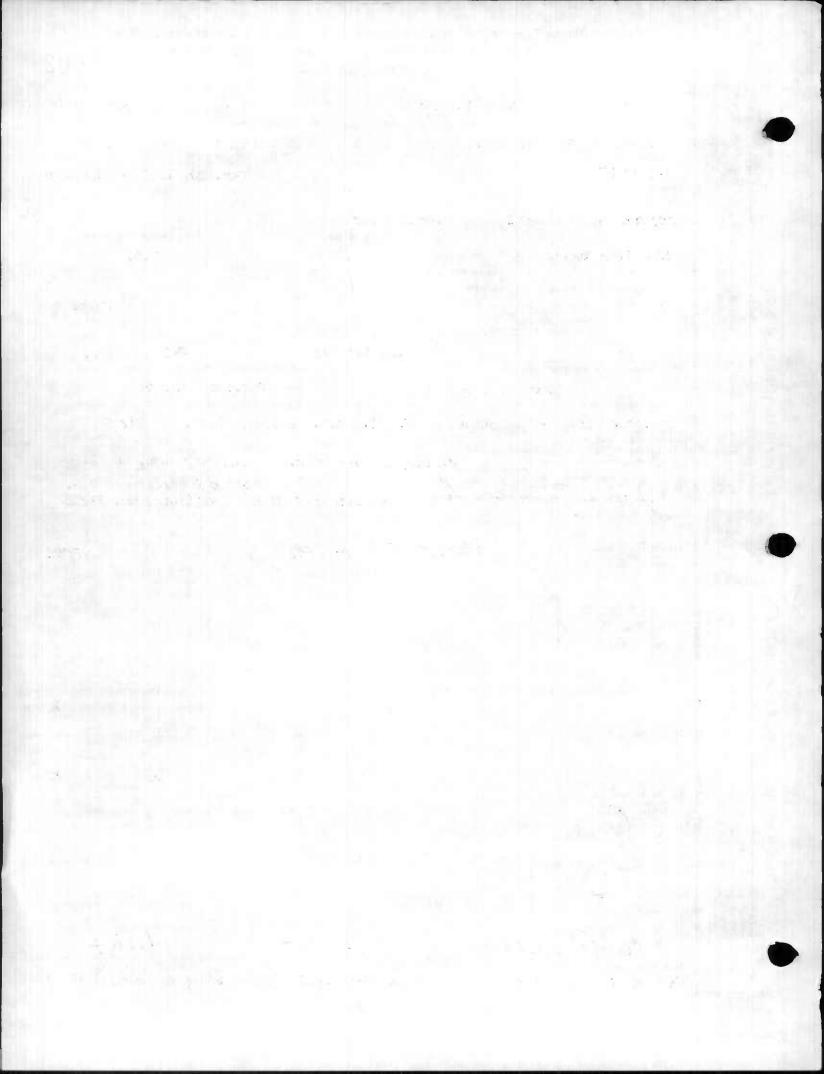


State of Maryland / Department of Health and Mental Hygiene

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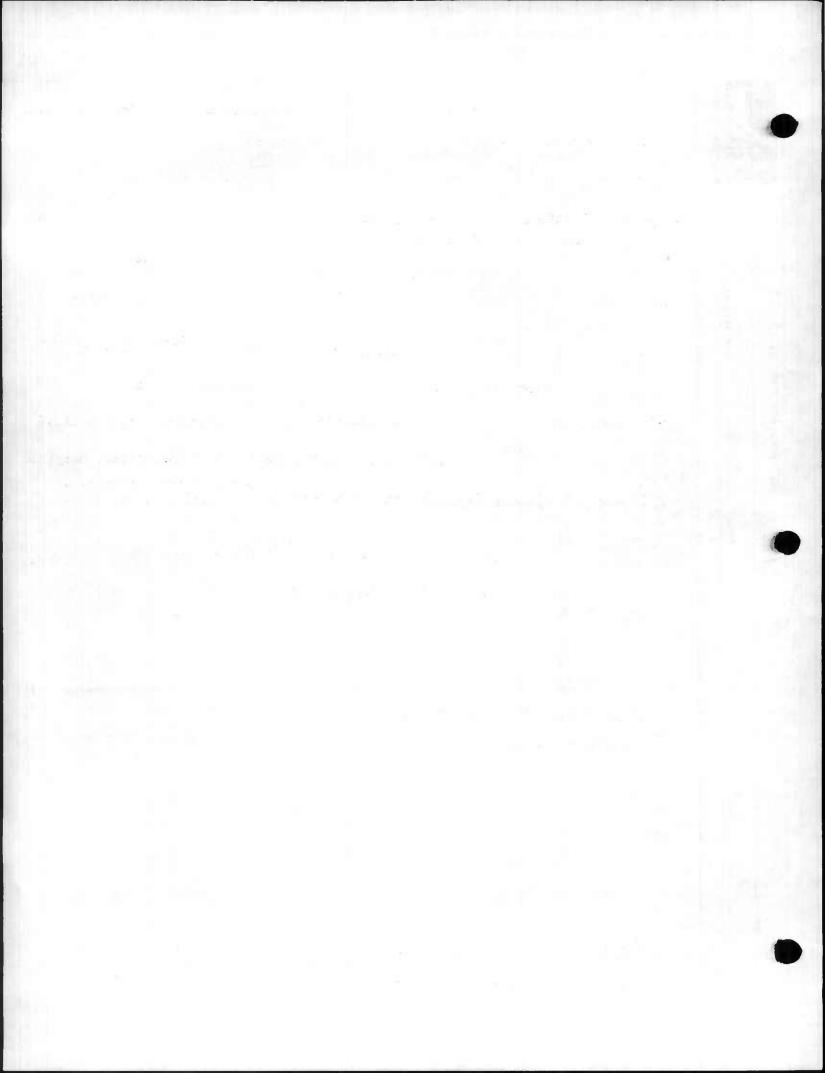
State Registrar

31. Date filed (Month, Day, Year)



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (35504 Certificate of Death Item:31, per V.R.11/25/97 reb 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** Month BROCKINGTON 05A ANN SHIRLEY 1100. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** AUE NUE 5359 CORDE/IA A BAHHURE if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 7. Aga (In yrs. lest birthday) 9. Birthplaca (Stata or Foraign Country) 1. Coro Lina 5. Social Sacurity Number 6. Sax Months Days 1 M 2 F 216-86-5512 Yrs. Usual Residence of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Nas 2 No Director BALTIMORE Marylano 10e. Streat and Number 10f. Zip Coda 10g. Citizan of What Country? 5359 U5A 21215 by Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 DeNo If Yas, Giva Yaar or Datas: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 13/ac/c Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Sacondary (0-12) OUN HOME Collage (1-4or 5+) HOME MAKER 12 # grode 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Meiden Sumeme) Be Brockington Mae Helen Jamison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Corpelia Aus Mas HELENFIRDE/NOTHER 5359 BAHINOR, Mary IDNO 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State Bunai 2 Cramation 3 Ramovai from Stata 11-25-97 WOODLAWW CEMERA WOODLAWN MARY INWAS SOLVER FUNERAL HOME SOLVE PEISTERSTOWN READ 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximata Intarval Batwo Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Obua to (or as e consequence of) Completed by Physician/Medical Examiner Sequentielly list conditions, if any, laading to immadiata causa. Entar Undarlying Ceuse (Disaasa or injury that initieted evants rasulting in deeth) Last Due to (or es a consequance of): Dua to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 Ho 1 ☐ Yes 2 ☐ No Be 25. Wes cesa refarred to medice! 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Aesidanca 8 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth Certification: 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending invastigation 1 Naturel

P.O. Records, of Vital or Attending Physician:

The lew requires that the death certificats be executed

Funeral

Director

Items 23a or 28a-f show iner must be notitied at

Pages 1 end 2 should be filed within 72 hours effer de ment of Health end Mental hygiene. ant: If Item 27 is marked other than "natural", or item ury or other traumatic event, the Medical Examene.

permit. Pages 1 end 2: Department of Health or Important: if item 27 is any injury or other trau

Physician /Medical

Examiner

and

physician

After this certificate

for use es

Maryland

Baltimore,

Division

fo the massive siter deeth.

To the Funeral Director: After this site to the funeral of the fune To the Høspital Medical

State Registrar

00 31. Deta find Month,

30. Name and addrass of person

2 Accidant

3 ☐ Sulcida

29a. Certifiar (Check only one) 29b. Signatura and titl

4 Homicide

Day, Year

6 Could not be

32. Registrer's Signatura

25

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

1 Cartifying Physicien: To the bast of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end mannar as stated.

2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and mannar stated.

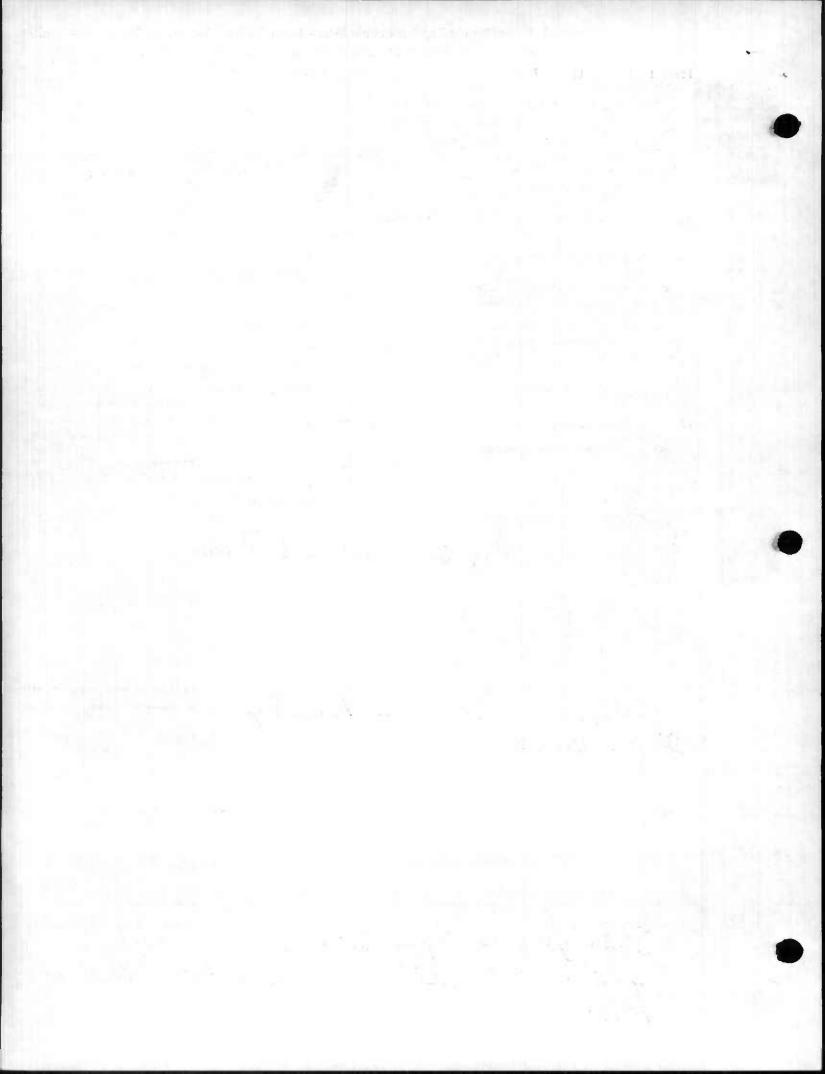
29c. Licansa numbar

1 ☐ Yas 2 ☐ No

28f. Location (Straat and Number or Rural Route Number, City or Town, Steta)

29d. Data signad (Month, Day, Year)

who Davidson



State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time I th Month Dey Brooks 4:18 pm November 20, 1997 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins Bayview Baitimore Hedical Center 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) July 30, 1 6. Sax Birthplece (State or Foreign
Country) Deys 10 M 20 F Months Hours 68 1929 Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No N/A Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 2000 O'Dell Avenue Apt 1913 21237 U. S. A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: 3 Nidowed 4 □ Divorced White Year or Detes 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Homemaker. Own Home 17. Fathar'e Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles Brooks Mary Dietrich 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bloch (Sister) 1647 North 73rd Ave., Phoenix, Arizona 85035 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 1 Ø Burial 2 ☐ Crametion 3 ☐ Removel from State Moreland Memorial Park 11/24/97 | Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Schumunek Funeral Home Inc. 21. Signeture of Funeral Service Licansee 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intarvel Batween Onset end Deeth e. Pulmonary embolism 1 hr Dua to (or es e consequança of): ibc MyocardiaL infarction Due to (or es e consequance of) Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yea 2 ☐ No chronic obstructive pulmonary discore 24b. Wara autopsy findings eveilable prior to completion of cause of deeth? 24a. Was en autopsy 1 Yas 20 No 1 ☐ Yes 2 No 25. Wes case referred to medical 28. Piece of Daath (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Yeer) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) tal Certifying Phyelcian: To the best of my knowledga, deeth occurred et tha tima, data and place, and dua to tha causa(s) and mennar es stated.

2 Madical Examinar: On the best of exeminetion end/or invastigation, in my opinion, deeth occurred et the time, dete end placa, and due to tha causa(s) end menner stated.

29c. License number

7025

Balt

MD

29d. Dete signed (Month, Dev. Year)

11-21-97

21224

The law requires that the death certificate be axecuted P.O. Box 68760, Records, of Vital lal or Attending Physician: The star death.

I Director: After this carificet ed in by the funeral director, pa Division To the Hospital o within 24 hours at To the Funeral Di

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification:

Medical

Funeral

Director

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r than "natural", or frems 23s or 28s-f show

traumatic event,

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permit. Pega Department of Important: If any Injury or

Physician

Examiner

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for usa as attanding

signed by tha

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cartificeta has page 2

filled

/Medical

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death with the Meryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

Vera

10e. Stete

Maryland

N/A

20e. Method of Disposition

immediata Causa (Finel diseese or condition resulting In daath)

Sequantially list conditions, if eny, laading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest

throat cancer

1 Yas 2 No

27. Manner of Deeth

1 SNaturel

2 Accident

3 ☐ Suicide

29e. Certifier (Check only one)

4 Homicide

10e. Street end Number

5. Sociel Security Number

216-18-6103

Usuei Residenca of Decedent

State Registrar

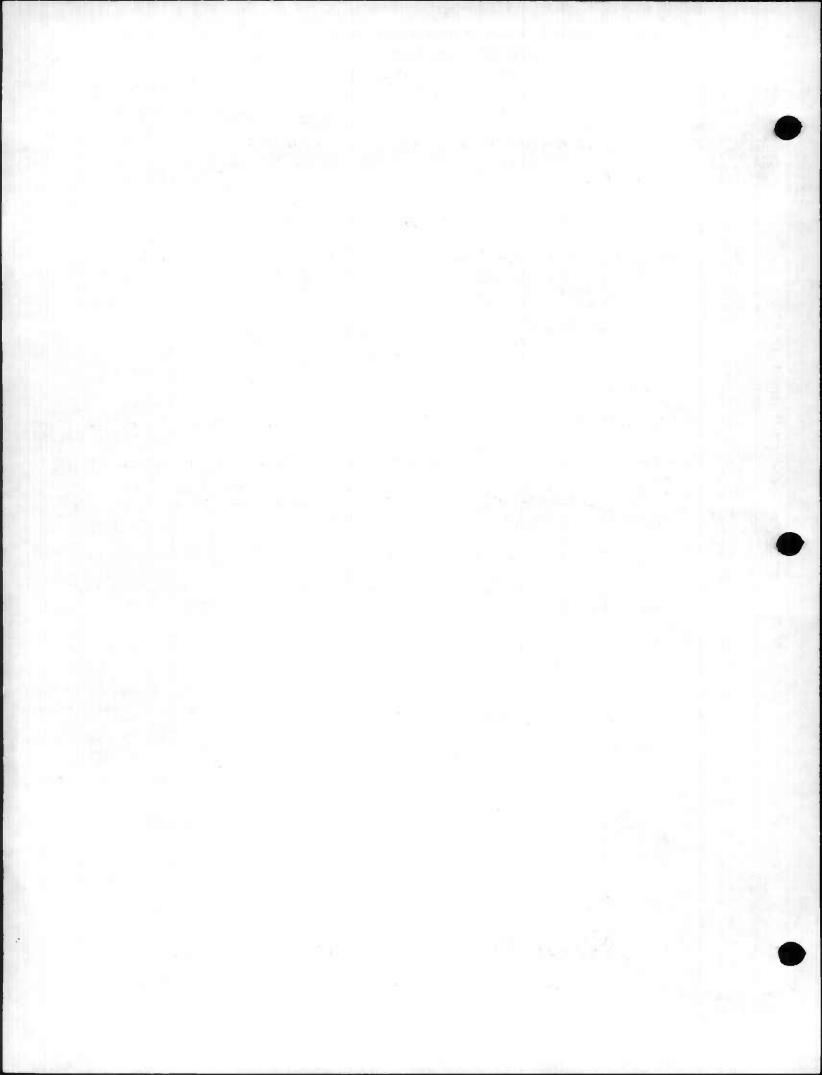
31. Dete filed (Month, Day, Year)

29b. Signeture end title of pertifier



30. Name end eddrass of person who complated causa of daath (itam 23a) (Type, Print)

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 7

		11.000				Certific	cate of	Death			. No.		
Physic	ian	1. Decedant's Nama (First, Mide							. M	ata of Death	Day	Yaar	3. Time of Death
/Med		MARY RUTH BOOT								o Vembe	23 1	997	4 P.M.
Exami	ner	4a. Facility Nama (if not instituti						4b. City, Town,		of Death	4c. County		,
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Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, The Managare.		4 Donation 5 Other (Highvi			Garde	ns 11/	26/97	Falls.	ton,	Maryland
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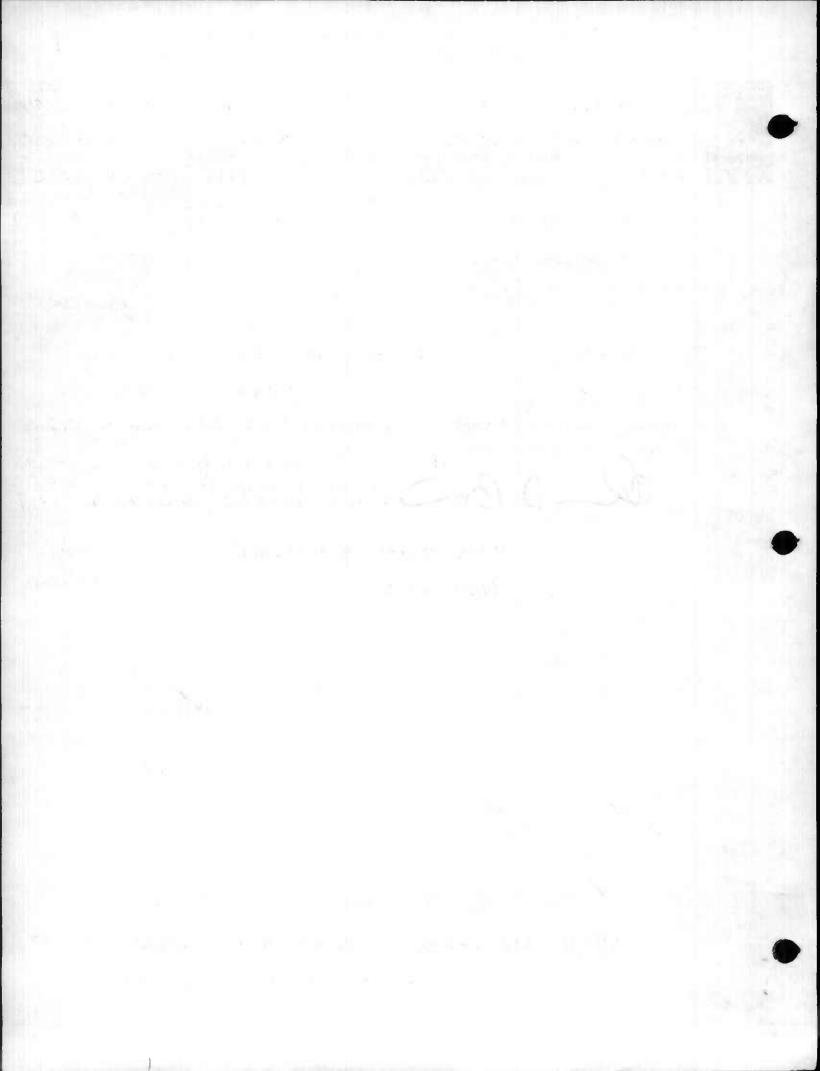
State Registrar

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Deeth 3. Time of Deeth Month NOVEMBER 16, 1997 **Physician** BURTON EVELYN 11.20 AM /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner BALTIMOLE HOSPITAL CENTER HARBOR | If Under 1 Year | If Under 24 Hrs. | Nonths | Deys | Hours | Min. | Hours | Min Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□M 2**X**F Yrs. UNKNOWN Director Usuel Residence of Decedent iral', or itema 23e or 28e-f show Examiner must be notified at 10a. Sfete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2□ No NIA BALTIMORE Director MARYLAND 10e. Streef and Number 10g. Citizan of What Country? 3027 AVENUE USA. Funeral 12. Was Decedanf Evar in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Detes: Raca - Amarican Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after compensation of Health and Mental hygiene.

Important: if them 27 is marked other then instural, or fren eny injury or other traumatic event, the Medical Experimentance. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 THGRADE WORKER 17. Fether's Neme (First, Middle, Lest) UNKNOWN WALLACE 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremetory or other place) BALTIMORE MD, 21215 late 20c. Location - City or Town, Stete NELLIE COLLINS (FRIEND 20e. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata Date MT. AUBURN CEMETERY 11-25-97 BALTIMORE, HARYLAND Other (Specify) 4 Donetion of Funerel Sarvica Licens 22. Name end Address of Fecility JOSEPH H. BROWN JR. FUNERAL Home, P.A. 40 N, FULTON AVE. BALTIMORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respirately arrast, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical HEMORRHAGE INTRACEREBRAL P days Examiner Due to (or as a consequenca of): Examiner NOT KNOWN MUMERTENSION Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): 68760 Physician/Medical the Due to (or as a consequenca of): P.O. 1 Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings avellebla prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? 1 🗆 Yes 2 0 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physicien: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Menger of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigetion 1 Neturel death. 1 Tyes 2 No 2 Accident Director: / 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the ceuse(s) end mannar stated. edicai 29a. Certifier (Check only one) 29b. Signature end fittle of cartifier 29d. Date signed (Month, Dey, Yeer) 29c. Licansa number 11 244 16 14 16, A97 10 KAMLER 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) BALTIMORE, MARYLAND TIOS PITAL HARBOR CENTER 31. Date filed (Month, Dey, Year) NOV 2 5 1997 State

Registrar



State of Maryland / Department of Health and Mental Hygiene 35508 Certificate of Death 1. Decadant's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** NOVEMBER 24 1997 Oscar Dana /Medical 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Baltimore Stella Maris Hospice at Mercy If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1**∑** M 2□ F Months Days Yrs. Director 56 302 38 3983 Dec. 11, 1940 Ohio 10e. State permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mantal Hygiane. Important: If item 27 is marked other than "natural", or fierma 23a or 28a-f show any Injury or other traumetic svent, the Modical Examiner must be inclined at once. 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimre Director Baltimore 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1724 Nome St. Apt A3 21224 United States 12. Was Dacadanf Evar in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Bleck, Whita, atc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: py 3 ☐ Widowed 4 ☑ Divorced Black Yaar or Datas Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 (Unknown) (Unknown) 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) (Unknown) (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) Emeke Anonyuo / Minister 1128 Punjab Dr., Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Ramoval from State 4 Donetion 5 Other (Specify) Green Mount Crematory 11/25/97 Baltimore, MD 22. Nama and Address of Facility CAFA Stephen D. Lohrmann P.A. an 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part 1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on each line. Approximate Intervel Between Onsaf and Death Physician /Medical Immediata Cause (Final disaase or condition resulting in death) **Examiner** Due to (or es e consequenca of): Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Disaase or Injury that Initiated events resulting in daeth) Last Dua to (or es a consequance of) P.O. Box 68760. physic Physician/Medical The law requires that the death certificete the Due to (or as a consequenca of): for usa as 88 Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably Thunknown Records, Be Completed by 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed? peen completion of causa of daath? ata has b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, I 25. Was case referred to medical examinar? 28. Placa of Daath (Check only one) STE //A MARIS AT MEREY Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 2 Naturel 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury af Work? 28d. Describe how Injury occurred Medical Certification: 5 Panding investigation Division Injury 1 Yes 2 No ₽ ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 T Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pieca, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data end piace, and due to the cause(s) end mannar stated. 29a. Certifier 29b. Signatura and fitla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) Junous 040480 NOVEMBER 24

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State Registrar

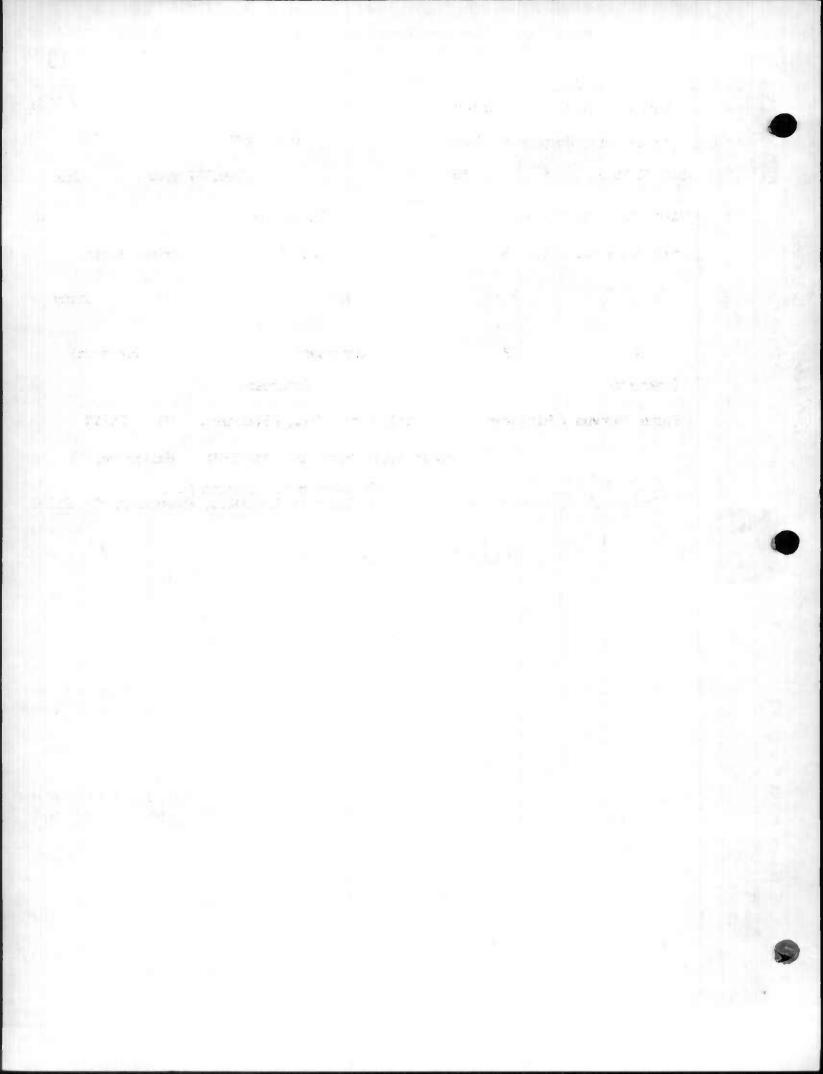
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30. Nama end eddrass of person who complated cause of death (Itam 23a) (Type, Print)

FERNANDO

31. Data filed (Month, Day, Year)

BROWN,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35509 Item #8 per FH G753 11/25/97 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month BOWEN 12ABGTH NOVEHBER 22 1030 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNZ HOPKINZ BAYVIEW LOSPITAZ BATTINORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Dave Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2AF 220-74-8557 Yrs. Director 84 Nov. 8/30/1913 Maryland Usual Residenca of Decadent r 28a-f show a notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 No 2 No Maryland N/A Baltimore 200 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 the Medical Examiner must be 1327 West Pratt Street Herms 23a 21223 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: ò Baltimore, Maryland 21215-0020 1 Yes 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced Specify: natural. white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 homemaker other t own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 2 should be fi end Mental F s marked ott Be Robert Hamilton Carrie Geneva Plowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 permit. Pages 1 and 2 a Department of Health er Important: If item 27 Is any injury or other trau once. Ethel Thomson, daughter 2204 Cambridge Street Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/26 Brooklyn, Maryland Ambrose Funeral Home, Inc. Arbutus 1328 sulphur Spring Road Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final TEN DAYS MEUMONIA disease or condition resulting in death) Examiner Due to (or es e consequence of Physician/Medical Examiner physician end the burief-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequenca of): be exec 68760. Due to (or as a consequenca of) ettending for use es Box P.O. 1 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown PULMONARY HUPERTENSION Records, ρ 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? peed CHRONIC OBSTRUCTIVE PULHONARY DISEASE page 2 : 1□Yes 2 No CACHEXIA 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certification of the Funeral Director, and the funeral director, it is a second to the funeral director. 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury et Work? 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

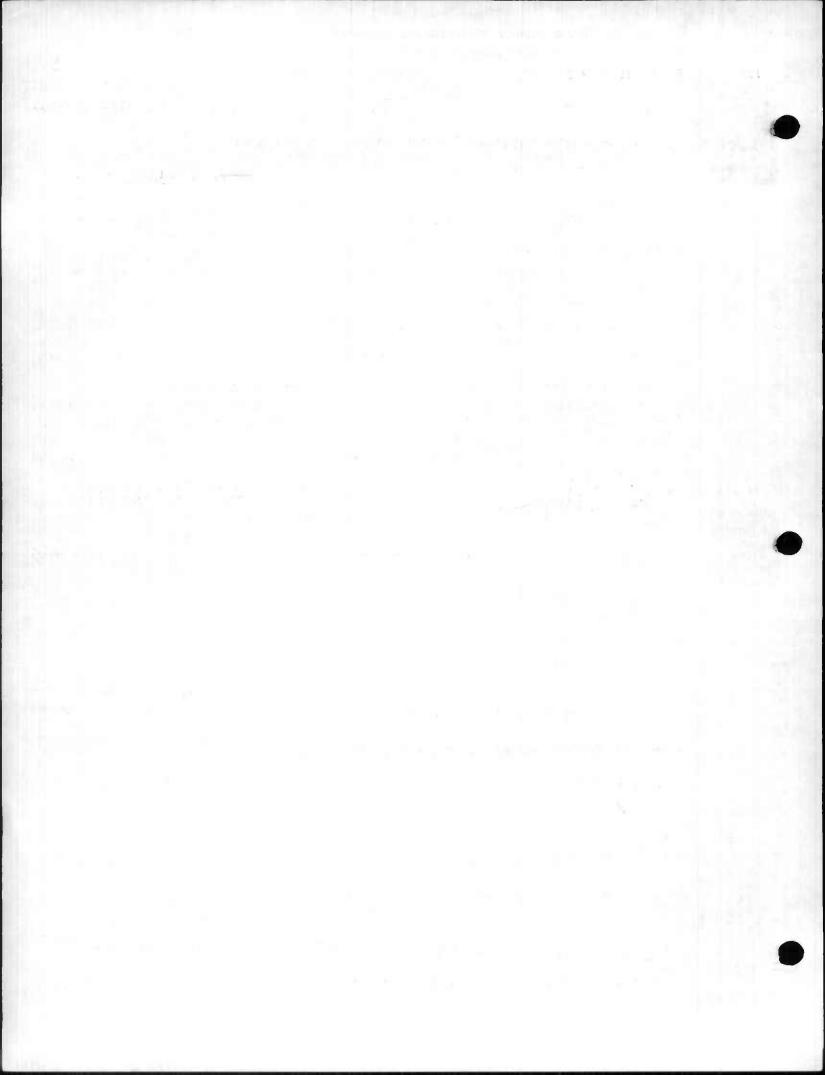
State Registrar 31. Date filed (Month, Day, Yeer) NOV 2 5 1997

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

OLWER BACON, MD. TOWER 110 JOHNS HORING HOPITA, 1600 NORTH WOLFE ST, BACINORE, 32. Registrat's Signature

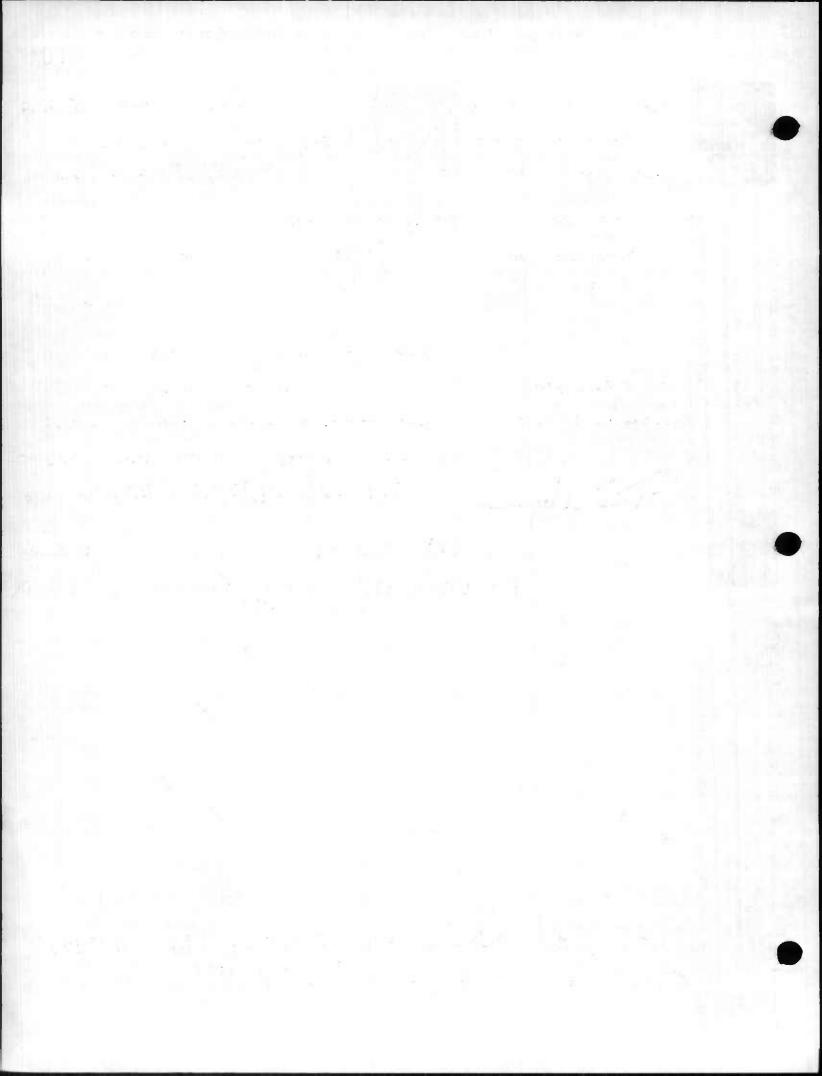
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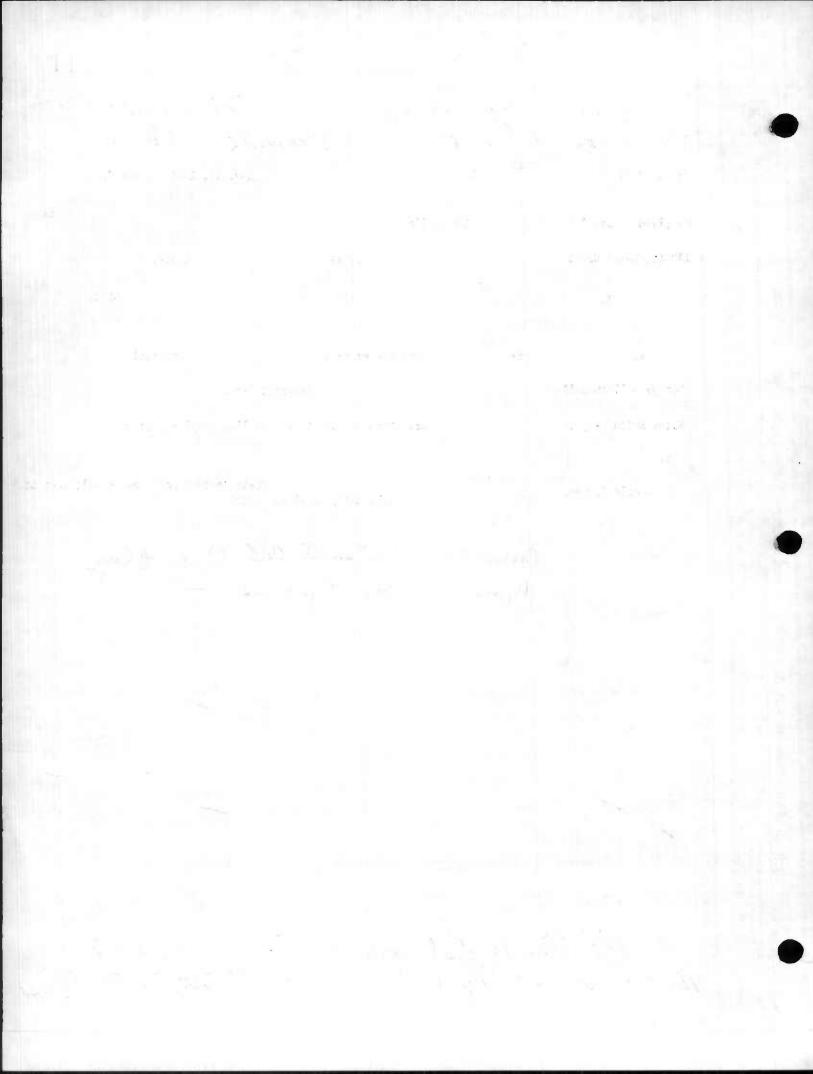
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State of Maryland / Department of Health and Mental Hygiene 9 7

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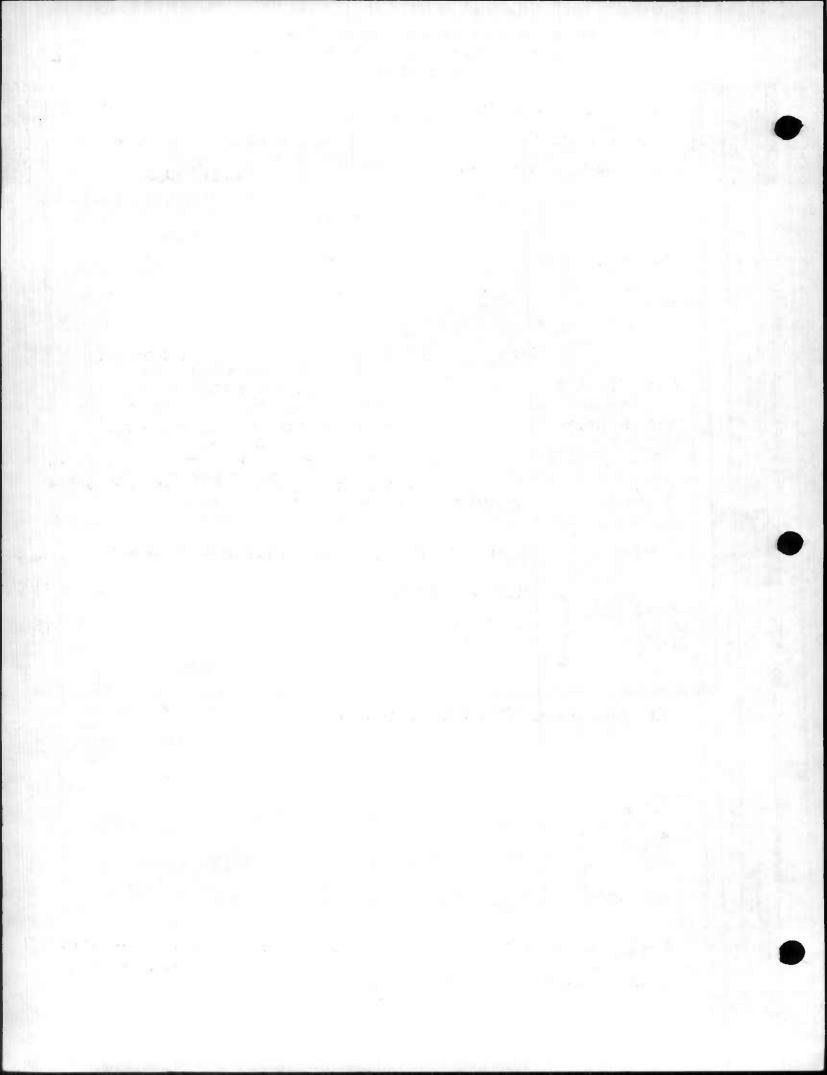
State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 7 355 | 2

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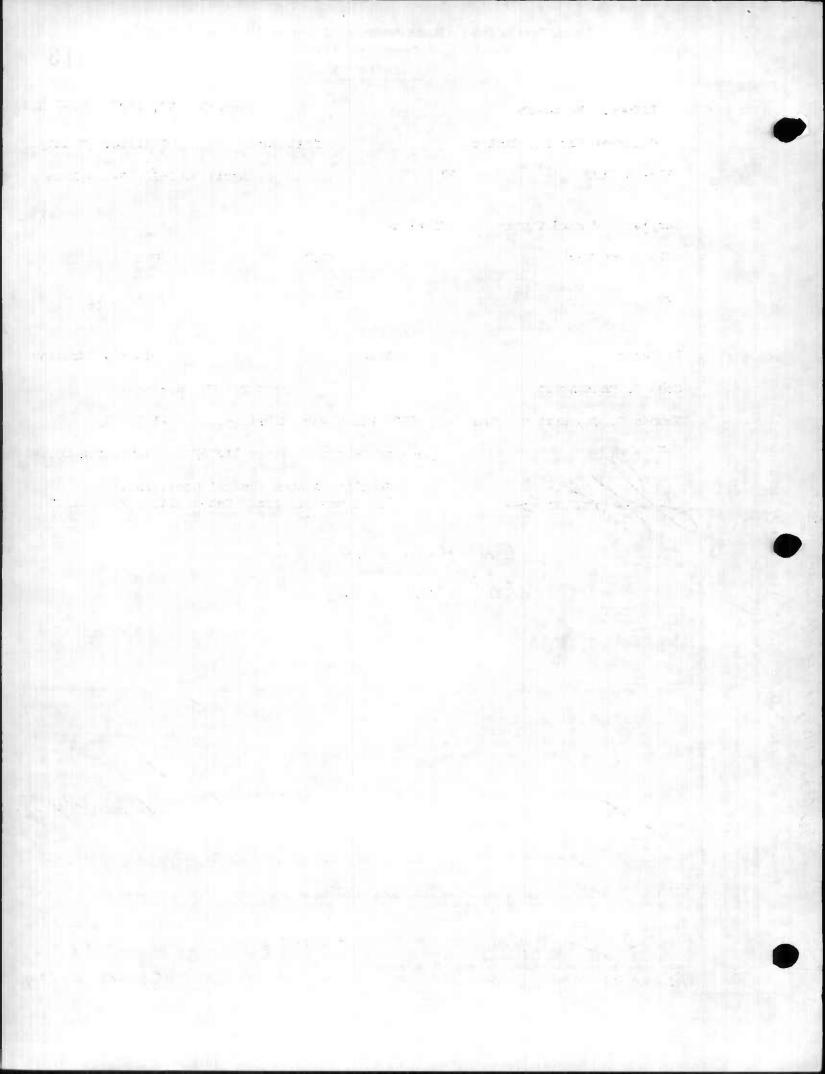


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miner	4a Fecility Neme (If not institution, g	ive street and number)			4	b. City, Tow	m, or Location	n of Death	4c. County	of Death		
	Gilcrest Nurs	ing Center				Towson			Balt	imore	Cour	ity
al	Social Security Number 6.	Sex 7. Age (In yrs. last birthday	/) If Under Months	1 Year Days	If Under 24 Hours		ete of Birth Nonth, Day, Y		9. Birthpl	ace (State	or Foreign
or	192-05-7120	TLAW 2	77 Yrs.				Ap	ril 8,	1920	Peni	nsylva	nia-
rector	Usuel Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation						16	od. Inside C	ity Limits
7	Tod. State		oc. Oxy, rounter a	LOCATION								2 ⊠ No
octo	Maryland Howard	County	Elkride								233	- 22
Funeral Director	10e. Street and Number			10f. Zip	Code			100	. Citizen of V	Vhat Coun	try?	
70	6725 Pirch Way				-	075			USA			
nue	11. Meritel Status	12. Was Decedent Eve Armed Forces?	er in U,S. 13	. Wes Deced	dent of Hi cify Cuba	ispanic Origi n, Mexican,	in? (Specify ' Puerto Ricar	res or No- i, etc.)		a - America k, White, o		
	1 Never Married 2 Married	1 Tyes 2 □ No		1□ Yes	2 XNo	Specify:			Specify	<i>r</i> :		
d by	Widowed 4 □ Divorced	Year or Dates:								Whi		
etec	15. Decedent's (Specify only highest g	Education rade completed)	16a. Dec (Giv	edent's Usua re kind of wo DO NOT us	al Occupa	ation du <i>ring</i> most o	of working	16	b. Kind of Bu	usiness/inc	lustry	
Be Completed	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life.	DO NOT u	se retired)						
Š	12 Years		I	lumbe	r						_Comp	any
Be	17. Father's Name (First, Middle, Les	st)				18. Mother	's Name (Firs	it, Middle, Ma	iden Suman	18)		
To	John J. Baumgart	en				Ma	argare	t W. O	pserma	ın		
	19a. Informant's Neme/Relationship	(Type, Print)					or Rural Ro		City or Town,	State, Zip	Code)	
	Thomas E. Baumga	rten - Son	672	25 Pir	ch W	ay El	lkridg	e, MD	2107	5		
	20a. Method of Disposition		20b. Place of Disp cemetery, cri	emetory or o	ther plac	a)	Da		c. Location -			
	1 Burial 2 □ Cremetion 3 4 □ Donation 5 □ Other (Spec		Queen	of He	aven	Cemet	tery 1	1/25/9	7 Was	hingt	con Co	., PA
	21. Signatury of Funeral Bervice Lic			22. Name an	nd Addres	s of Facility	,					
	V/16-	2		Sterl	ing	Ashtor	n Fune	ral Ho	me, In	C.		
_	faller on	44	- d	736 E	dmon	dson A	Ave.	Catons	ville,	MD	2122	
1	23a Part1, Friter the disease, or co shoot or heart failure. List on	y one cause on each line.	e death. Do not e	nier ine mod	e or dyin	g, such as c	ardiac or res	piratory erres	ι,		Approxima Interval Be Onset and	tween
n 📑										1	Oriset and	Doeili
r	Immediate Cause (Final disease or condition	. End	stage in to for es ocons	CH	F					1		
1.	resulting in death)	Di	e to (or es cons	equence of):								
9		End	stage	COF	212							
93					~							
ă	Sequentially list conditions,		Due to (or as (consequence of):							1		
	Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying									1		
ical	Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	e to (or as e conse							1		
fedical	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	cDu	e to (or as e conse									
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8	resulting in death) Lest	d		equenca of):	ause divi	on in Part I		23b. Dld tob	acco usa co	ntribute to	the cause	of death?
8	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other aignificant conditions	d		equenca of):	sause giv	on in Part I.		-				1175
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by Physician/M	resulting in death) Lest	d		equenca of):	ause giv	on in Part I.		1 ☑ Ye	2 □ No	3 ☐ Prot	pably 4	Unknow
by Physician/M	resulting in death) Lest	d		equenca of):	sause givi	en in Part I.		1 🗹 Y 👓	2 □ No	3 ☐ Prot	pebly 4 pere autopsy milable prior mpletion of	Unknow
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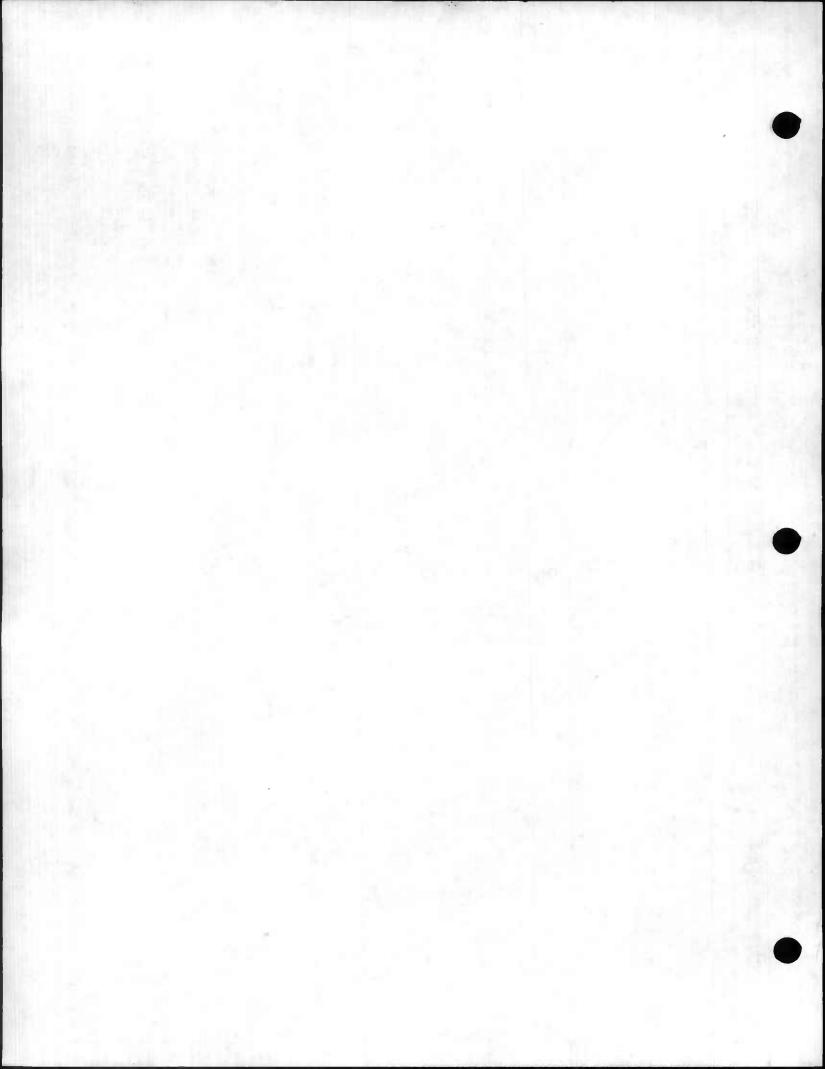


VOID
CERTIFICATE # 35519/_

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CERTIFICATE M

37/43



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 18 per F.H. G-754 12/1/97 reb 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Surton NENDALI 01 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Arundel HOSP If Under 24 Hrs. 8. Date of Birth GeN HUNE If Under 1 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2□ F 008-14-1755 72 Director Vermont Usual Residence of Deceden the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2€ No Director Windsor Chester 10e. Streef and Number 10f. Zip Code 10g. Citizen of Whet Country? Dodge Road 05143 U.S.A. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedenf Ever in U,S. Armed Forces? 14. Raca - American Indien, Black, Whife, etc. 11. Maritei Status 72 hours efter 1 X Yes 2 □ No
If Yes, Give
Yeer or Dates: 44-45 1 Never Married 28 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I filed within 7 I Hygiene. Elementery/Secondery (0-12) Coilege (1-4or 5+) 11 Machinist Metal/Foundry Pages 1 and 2 should be filed an ent of Health and Mental Hygic int: if item 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Herman Burton, Sr. Alice Maude Springfield Howe 19a. Informanf's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 Department of Health el Important: if item 27 is any injury or other trau Gladys Burton / Spouse 3121 Port Way, Annapolis, MD 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Sfete 1 ☐ Burial 2 Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, Maryland 11/25 21. Signature of Funeral Sen 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused key death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear failure. List only one ceuse on each line. **Physician** rteriosclerotic Heart Disease /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequença of) P.O. Box 68760 8 Physician/Medical the Due to (or es a consequence of): 88 for use as Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? 3 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b Records, by 24a. Was en eutopsy performed? 24b. Were autopsy findings aveilebte prior to completion of cause of death? Completed pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Vital To the Hospital or Attending Physician: within 24 hours effer death.

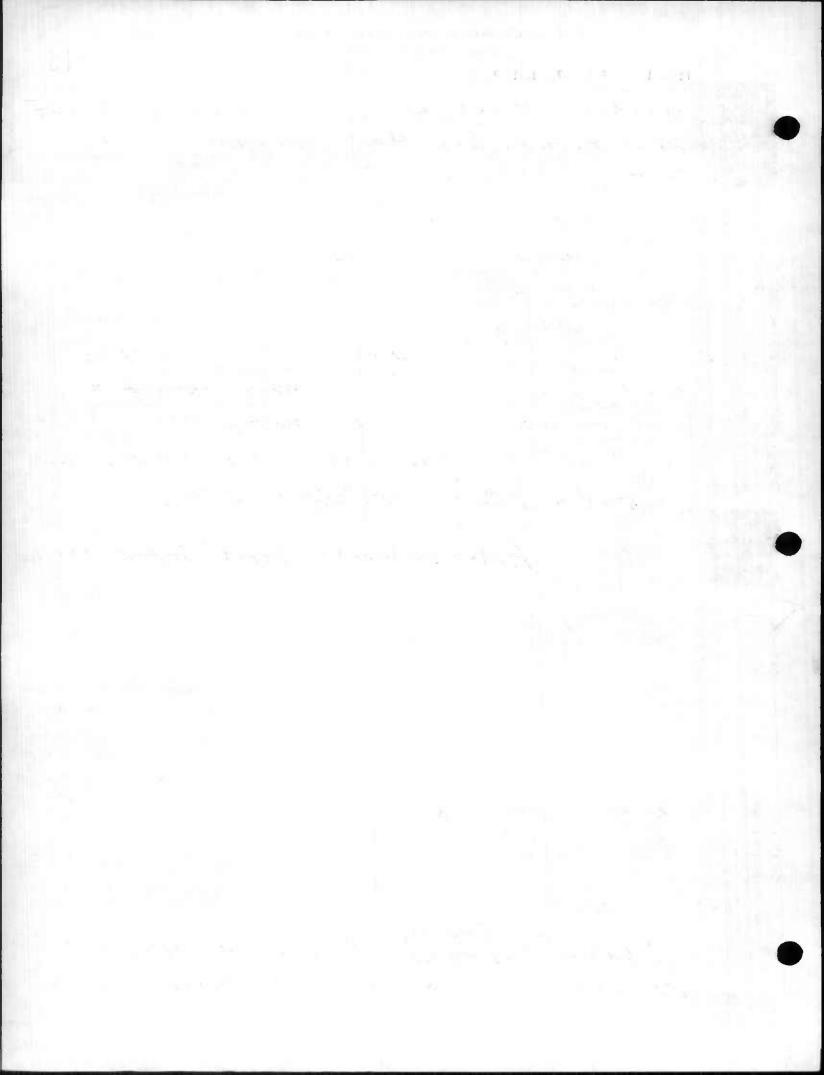
To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XYes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA jo 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of thiury 28c. Injury et Work? Division 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide edicai 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier 29b. Signature end fitte of certifier eputy and eddress of person se of deeth (item 23a) (Type, Print) mon ONES 1/1/ Am NOV 2 5 1997 32 Registrar's Signeture State

ia Davidson

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 4.DWIN NOVEMBER 21 4e. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth OSPITAL GLEN BURNIE If Under 1 Year | if Under 24 Hrs. 8. Det of B. PUNDEL HNNE ORTH RUNDEL 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1□M 2□ F Months Days Hours 217-26-0864 66 Yrs. Mar. 8, 1931 Maryland Usuei Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Severn 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7970 Foster Ave. 21144 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) Contractor Construction 8 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Casper N. Barnes Thelma M. Weedon 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Barnes/ Daughter 7970 Foster Ave., Severn, Maryland 21144 20b. Placa of Disposition (Name of cemetery, crematory or other place) Nov. 24 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Pk. 1997 Glen Burnie, Maryland of Funeral Service Licenses 21. Signatu 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. PNEUMONIA immediate Cause (Final disease or condition resulting in death) Saquentially list conditions.

Physician /Medical **Examiner**

68760,

Division of Vital Records, P.O. Box

Physician

/Medical

Examiner

Director

Funerai

py

Completed

Be

Funeral

Director

r than "natural", or Items 23s or 28s-f show the Wed cal Examiner trust be netfred at

permit. Pages 1 and 2 should be filed within 72 hours pepartment of health and Mental Hygiene. Important: If than 27 is marked other than "natural", any injury or other traumatic event, me than any injury or other traumatic event, me than any injury or other traumatic event, me than one institution.

the Maryland

DARNES, EDWIN

Examín

the attending phys To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director,

Physician/Medicai by Completed To Be Certification:

State Registrar

Medical

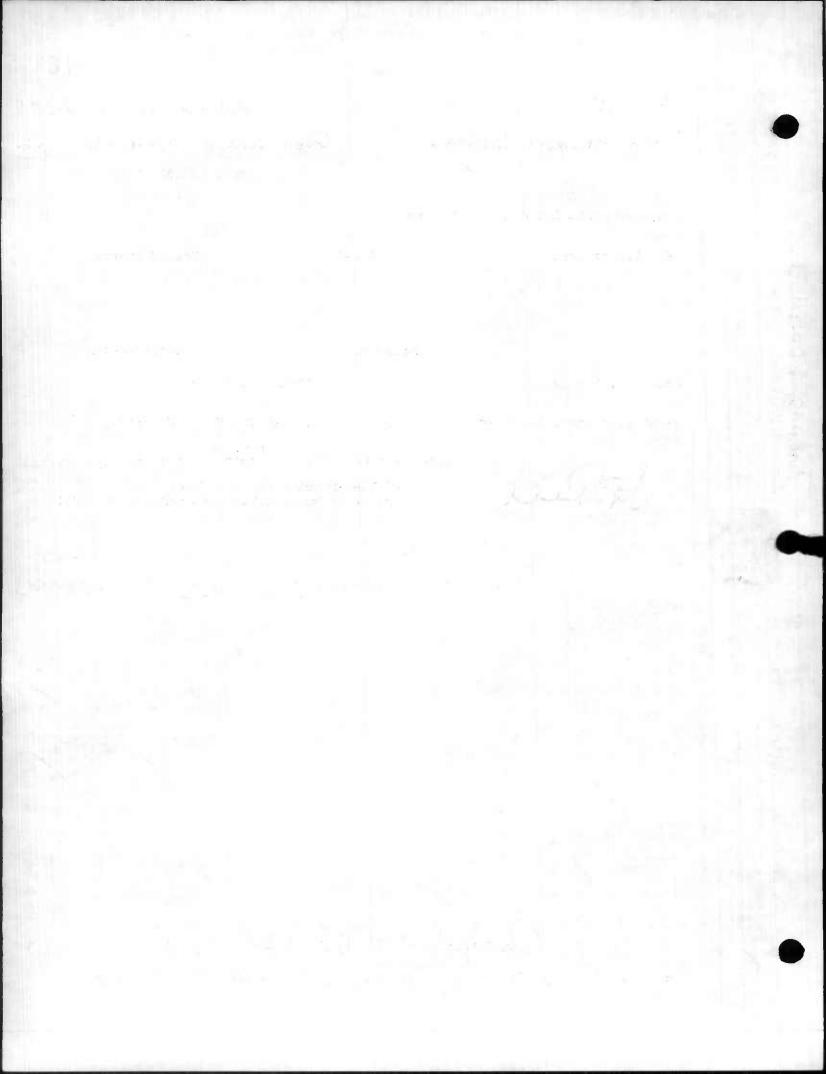
29b. Signature and title of certifier

if any, leading to immediate cause. Entar Undartying Causa (Disaase or Injury thet initiated events resulting in death) Last	cDue to (or as a consequenca of):	
Part il. Other algnificant condition	a contributing to death but not ra	sulting in the underlying	cause given in Part I.	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
-				24a. Was an autopsy periormed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes Y
25. Was casa referred to medical			26. Place of D	eath (Check only one)
examinar?	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ 0	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Panding 2 Accident Investiga		28b. Time of Injury	28c. injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
3 Suicide 6 Could no date min	28e. Placa of Injury - At I building, etc. (Spec	homa, farm, street, factorify)	ory, offica	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifiar (Check only one) 12 Certifying 2 Medical Ex	Physician: To the best of my kn kaminer: On the basis of axamin and mannar stated.	owladge, death occurre ation and/or invastigation	d at the time, date and place on, in my opinion, death occ	ca, and dua to the cause(s) and mannar as stated. curred at the time, data and place, and due to the cause(s)

29d. Dete signed (Month, Day, Year)

1)28221 November 21,1997 Vor Dr Grundel HESPITAC CHREIBFEDER 22. Registrars Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death November 24, 1997 **Physician** Virginia May 7:45 a.m. /Medicai 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long Green Nursing Home Baltimore Baltimore City If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1 ☐ M 2 💢 F 91 Yrs. 220-09-5627 May 3, 1906 Baltimore, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Baltimore Baltimore County Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2907 B Andorra Court Apartment C Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American indian, Biack, White, etc. 1 Yes 2 No If Yes, Give Yaar or Dates: 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yas 2 ☒ No Specify: White þ 3 Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A Housewife Housekeeping-Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Surnama) Annie Brickle Raymond Gurney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Lawrence F. Bruder (Son) 6911 Beech Avenue Baltimore, Maryland 21206 20a. Method of Disposition 20b. Piaca of Disposition (Name of cemetery, crematory or othar place) 20c. Location - City or Town, Stata 1XXBurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 Donation 5 Other (Specify) Parkwood Cemetery November 26, 1997 Baltimore, Maryland 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Lassahn Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236-4625 Approximate Intervel Between Onset and Death Immediate Cause (Final aspirat disease or condition resulting in death) Due to (or es a consequence of) maemi Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Degenentive Due to (or as a consequenca of): Intern Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performad? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piace of Death (Check only one) Hospitai: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 27. Manner of Death 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident

68760, cale be Physician/Medical attending p Box P.O. ed by the detached should be deta Records, p The law requires Be Completed page 2 : certificate of Vital Hospital or Attending Physicien: 24 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director. Certification: To Division To the Hospital owithin 24 hours aff To the Funeral Dicompletely filled in

Funeral

Director

7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Moultal Examiner must be nothed at

the Maryland

72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If hem 27 is merked other than 'n any Injury or other traumatic avant

Physician /Medicai

Examiner

Baltimore, Maryland 21215-0020

3 Suicide 6 Could not be determined 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 ☐ HomicIde 1 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(a) and manner stated. 29a Certifier

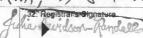
29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifian D 31464

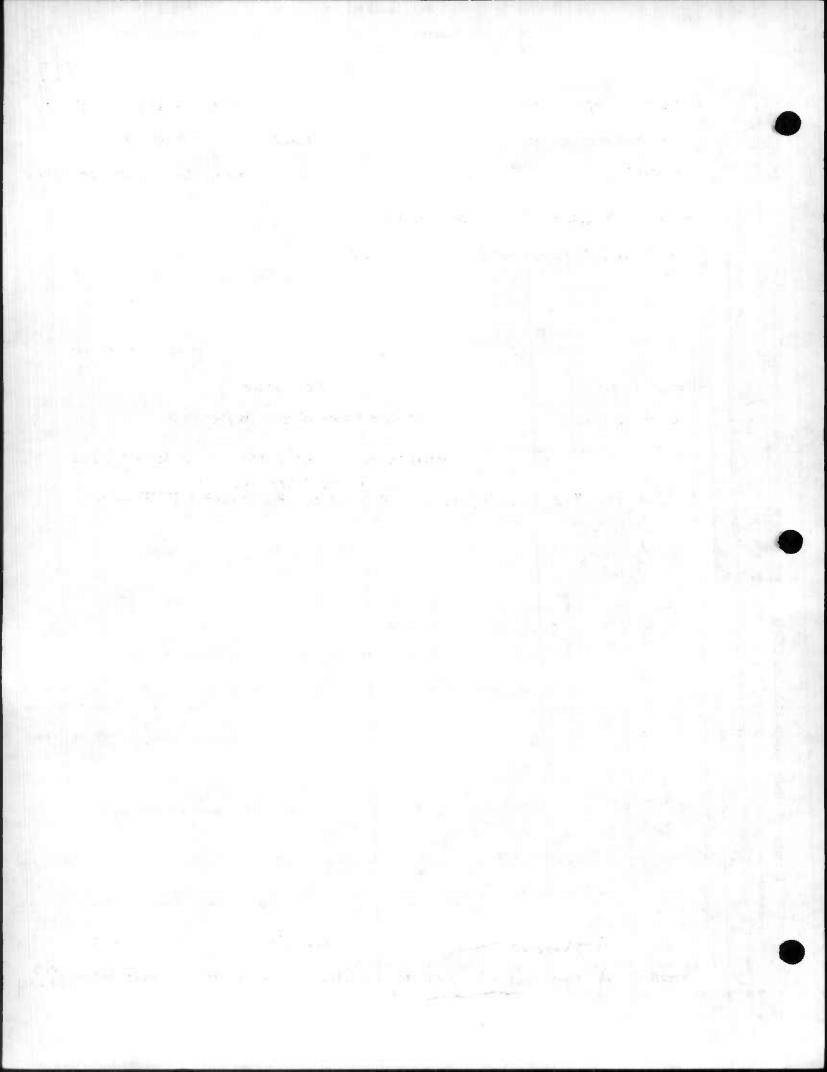
30. Name end address of person who completed cause of death (Item 23a) (Type, Print).
SHOALIS A. HAS HMI, MD, S21 N. ENTAN ST Smitz 705, Baltimuse 2120 31. Date filed (Month, Day, Year)

State NOV 2 Registrar

5

Medical



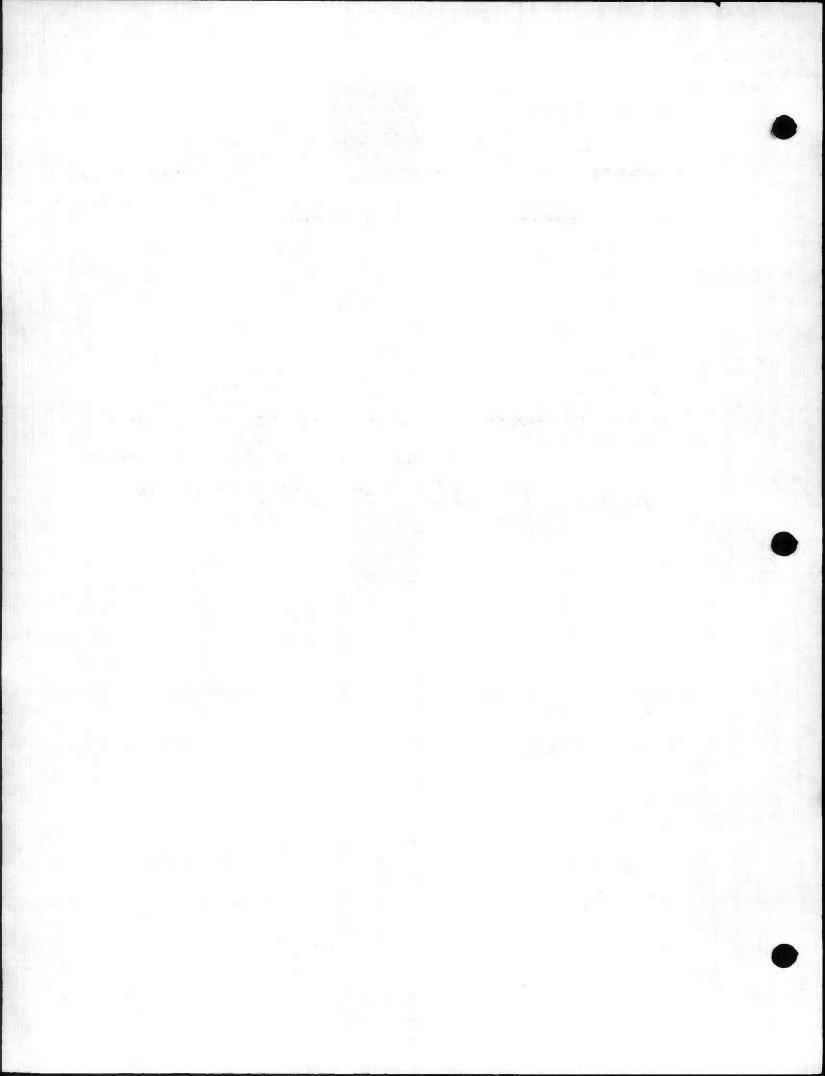


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 40 Bayer Francis /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Balto M 9200 Franklin Sq. Blvd. BALTO, Co tranklin Wood If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug. 15,1907 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sex 9. Birthplaca (Stata or Foreign **Funeral** Days 100M 20 F Yrs. 213-07-6893 Director 90 Indiana Usual Residence of Decedant the Maryland 10a, Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Nems 23s or 28s-f show traumstic event, the Medical Examiner must be nothed at 1 ☐ Yas 2 No Director Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? WITH 213 Ballard Ave. 21220 TISA death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 □ Nevar Marriad 2 □ Married Baltimore, Maryland 21215-0020 White 1 ☐ Yas 2 ☐ No Specify: À 3 XWidowed 4 □ Divorced Completed 16a, Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT use retired) (Specify only highast grada complated) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if hem 27 is marked other than any injury or other traumant. Collega (1-4or 5+) Elamentery/Secondary (0-12) Inspector Beth Steel 8th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Frank Bayer Mary Manley 0 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary Lou Efford/daughter 213 Ballard Ave. Baltimore Md. 21220 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ₺ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 11/26/97 Ebenezer Cemetery Baltimore Md. 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Sarvice Licensas 22. Nama and Addrass of Facility Connelly Funeral Home of Essex erry 300 Mace Ave. Baltimore MD. 21221 and anter the mode of dying, such as cardiac or respiratory arrast, 23a. Part1. Entar tha disaasa, or shock, or haart failura. List pu Approximate interval Between Onsat and Death **Physician** Immediata Cause (Finel disaesa or condition resulting in daath) /Medical Examiner Dua to (or as a consequence of) Examiner **burial-transit** Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in death) Last and Dua to (or as a consequance of): certificate be exec P.O. Box 68760. attending physician for use as the buria Physician/Medical Dua to (or as a consequence of) use as signed by the a Part fl. Other significant conditions contributing to death but not rasuiting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ¥ Yes 2 □ No 3 Probably 4 Unknown Records, 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peeu certificate has page 2 2 1 No 211No Division of Vital Attending Physician: 25. Wes casa refar ed to medical axaminar? Be 28. Piece of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 10 1 yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of fnjury (Month, Day Year) 27. Manhar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Injury 5 Pending invastigation 1 Metural death. NA NA 1 Yas To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fi 2 Accidant 6 Could not be datarmined 3 Cuicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 ☐ Homleide 1 Certifying Physicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. Licensa number mpre, mo 2123 30. Nama and address of person w completed causa of death (Item 23a) (Type, Print) DUOTE DRIVE 31. Data filed (Month, Day, Year) 32. Flegistrar's Signatura State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 7

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month November 22,1997 BUTLER 6:50 PM Raeford /Medical 4e. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Center Rosedale Baltimore if Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Feb. 22, 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months 0X) M 2 F North Carolina Yrs Director 68 Feb. 1929 240-34-4999 Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 6405 Hazelwood Avenue 21237 U.S.A. items 23a Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Bleck, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 1 XYes 2 No If Yes, Give 1/7/52— Year or Dates: 5 Baitimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced "natural". 12/9/53. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Vehicle Body Shop permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Ne Elementery/Secondery (0-12) College (1-4or 5+) Supervisor for Bakery 8th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Be Murdock Butler Elizabeth 2 19e. Intorment's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Beatrice L. Butler/Wife 6405 Hazelwood Avenue, Baltimore, Maryland 21237 20b. Place at Disposition (Name of cametery, crematory or other place) 11/26/97 Dete 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removel from State Dulaney Valley Memorial Gardens Timonium, Maryland 5 ☐ Other (Specify) 22. Name and Address of Fecility
John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206 of Funerel Service Lice uanita in or the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, in or the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, in or the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the disease, or complications that caused the deeth. somas Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel 20 Days diseese or condition resulting in deeth) e Stroke Examiner Due to (or es e consequence of): Examiner Lung Cancer burial-transit certificata be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest and Due to (or es e consequence of): Box 68760. physician Physician/Medicai the Due to (or es e consequenca ot): USB as attanding p P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 3 210 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy tindings aveileble prior to Completed 24e. Wes en eutopsy peen completion of cause of deeth? has paga 2 212 No certificata 1 Yes 1 ∏Yes 2 ∏ No Division of Vital Attending Physician: director. Be 25. Wes case reterred to medical 26. Place ot Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 10 1 Dipatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hespital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manper ot Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

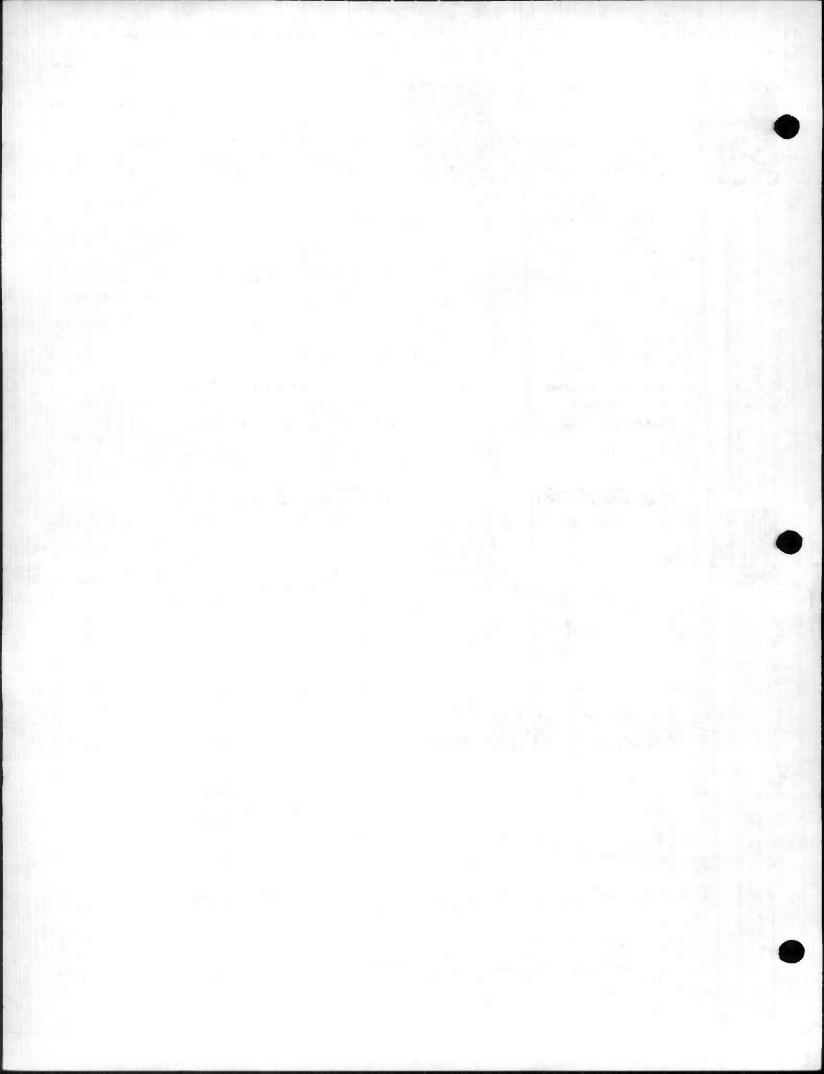
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only onel 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) November 22,1997 RD# 02119 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Ronald Jeffreys D.O. 9000 Franklin Square Dr. Balto, Md. 21237 32. Registrar's Signature
wha widson-frandess. 31. Dete tiled (Month, Day, Yeer) NOV 2 5 1997

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State of Maryland / Department of Health and Mental Hygiene 9 7 35520

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/Med Exam		4a. Facility Nama (If not institution, giva	street and number)				4b. City, Tov		ation of Death	4c. County		72.75	
		Manor Care Nursi	ing Center	- Ross	ville		Bal	timo	re	Bal	etimo.	re	
Funera Directo	_	5. Social Sacurity Number 338-07-5131	7. Aga	(In yrs. last bir	thday) If Und Month	ar 1 Yaar s Days		Min.	B. Data of Birth (Month, Day, Sept. 1,			laca (Stata or Foraign try) NOUS	
p 2		Usual Residence of Decedent											
Aanyle f shor	5	10a. Stata 10b. County 10c. City, Town or Location Maryland Baltimore Baltimore						10d. Insida City 1 ☐ Yas 2					
the A	ect	10e. Street and Number	·e			ip Coda			10	g. Citizen of V	What Coun		
ath with 23a or	Funeral Director	7310 Gunpowder Road 21220											
21215-0020 4 within 72 hours after death with the Manylend jiens. 7 than "natural", or items 23s or 28s-f show the Manylend at the Manylen Brancher must be notified at	by	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant E Armed Forcas? 1 XYas 2 No It Yas, Giva Yaar or Datas: (J	0			Hispanic Orlgoan, Maxican, Specify:	gin? (Spec , Puarto Ri	ify Yas or No- ican, atc.)		e - Amaric ck, Whita, :: Wh		
5-0 72 hv	eted	15. Decedant's Edi (Specify only highest grad	ucation (a complated)	16a.	Decedant's Us	ual Occu	pation dunna most	of working	1	6b. Kind ot Bu	siness/ind	dustry	
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re, Marylars s 1 end 2 should thealth end Marke other traumatic		Stephen F. Crum	(son)				der Rd	., Bo	altimore	-	2122		
Baltimore, N permit. Pages 1 end Department of Health important: if item 27 any injury or other to		20a. Mathod of Disposition 1 ☐ Burlai 2 ☑ Cramation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Spacify,		cameter	Disposition (N ry, cramatory of Mount	othar pla		11		oc. Location - Baltimo		wn, Stata Maryland	
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P.O. the the ded by the detached	/ Physician/								24a. Was an autopsy performed? 24b. Wara autops			pably 412 Onknown	
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be assocuted this certificate has been signed by the ettending physician end ral director, page 2 should be detached for use as the burial-transit	leted by											ara autopsy tindings alleble prior to mpletion ot causa	
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of ohysic this control	70	1 Yes 2 No	Hospital: 1 🔲 Inpatian		tpatient 3 0	AUK			9 5 ☐ Rasidar			1)	
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Division of the Hospital or Attending Phenishing 24 hours after deeth. To the Funeral Director: After the completery filled in by the funeral	Medical C	29e. Cartifier (Check only one)	alcian: To the bast of ner: On tha basis of e and mannar state	examination and	, death occurre d/or investigation	d at tha ti	ima, data and opinion, daati	d place, an h occurred	d dua to tha car I et the time, de	usa(s) and ma te end place,	innar es st and due to	ated. the cause(s)	
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Н		30. Name end eddrass of person who co	empleted cause of dec	oth (Itam 23a) (Type, Print)) (A) F	14. 6	BAL	TIMOR	E . M	D -	21231.	
St	ate	31. Data tiled (Month, Day, Yaar)		s Signature			- ' '	-					



DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020 TO THE HISPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. If them 28 is needed, for them 23 shows any inlury, or other traumatic event, the medical examiner must be notified at once.	
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	FOR STATE OF MARY				NTAL HYGIENE		
_	REGISTRAR	CERTIFIC	ATE OF	DEATH	REG. NO.		
- 18	t. DECEDENT'S NAME (First, Middle, Last)			2	DATE OF OEATH DAY	YEAR	3. TIME OF DEATH
- 1	Jack D. Carp	per		1	JOVEMBER		
			F UNDER 1 YEAR		DATE OF BIRTH (Month, Day, Year)		RTHPLACE (State or Foreign
	234-42-7742 11₺ № 2 🗆 ғ	71 YRS. MC	ONTHS DAYS	HOURS MIN.	June 2, 192	26 Ÿ	irginia
	9e. FACILITY NAME (If not institution, give street and number)			R LOCATION OF DEAT	Н 9	c. COUNTY O	
5	ST. ACMES HOSPIT	AL I	SALT	rimor	35	N	/XI
DINECTOR	RESIDENCE OF DECEDENT						113
	100. STATE 10b. COUNTY		TOWN OR LOCAT				10d. INSIDE CITY LIMITS?
	Maryland // /N	Ba	ltimore				t X YES 2 NO
2	10e. STREET AND NUMBER		101	. ZIP COOE	10	Dg. CITIZEN O	F WHAT COUNTRY?
LONEDAL	921 Brookland Avenue			21231		US	A
5	11. MARITAL STATUS 12. WAS OECEDENT EVER FORCES? 1 X YES	IN U.S. ARMED			ORIGIN? (Specify Yes or	No- 14. R	ACE American Indien, lack, White, etc.
	1 Never Merried 2 Merried FORCES? 1 N YES 3 Wildowed 4 M Divorced FYES, GIVE WAR OR	OATES		ecify Cuban, Mexican, I 2 NO Specify:	ruento mican, atc.)		pecify:
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	ts. DECEDENT'S EDUCATION (Specify only highest grade completed)	16e. DECEDENT'S US (Give kind of work	k done durina ma	ON st of working	16b. KINO OF BUSINE	ESS/INDUSTR	Y
COMPLE	Elementary/Secondary (0-12) College (1-4 or 5 +)	life. Do NOT use n	s Opera	ton	Drin	nting	
	10	Pres	2 oher a	LUI	ri II	TUTTING	
3	17. FATHER'S NAME (First, Middle, Last)				(First, Middle, Maiden Sur		
10	Thomas Carper, Sr.			Evelyn	Mae K	idwell	
	190. INFORMANT'S NAME (Type/Print)	19b. MAILING AT	DDRESS (Street a	and Number of Rural Rou	nte Number, City or Town, S	itate, Zip Code;	
	Blanch Bartlett - Sister	127 Am	erican	Avenue, B	Baltimore,	MD 21	1227
		06. PLACE AND DATE OF			OATE 20c. LOCAT		
	4 Donation 6 Other (Specify)	Mary Tand V			11/17 C		
4	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME A	ND ADDRESS OF FACIL	" Stallin	gs Fur	eral Home, P.
	▶ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\				Rd., Pasad		
	22 DAPT I Felor the diseases as application						
	23. PART I. Enter the diseases, or completations that caus shock, or heart failure. List only one cause on	ea ine death. Do noi each line.	enter the mo	de of dying, such a	na cardiac or respirat	ory arrest,	Approximata Interval Between
	IMMEDIATE CAUSE (Final						Onset and Death
	disease or condition a. LUNG	ADEV	10-0	AISCIN	OMA		Smonths
		A CONSEQUENCE OF):					110
-	Sequentially list conditions,						loyears
	to to to as	A CONSEQUENCE OF):	+ -				4
3	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	ic Hear	1 +	-culure			Lears
MULICALION							2 +-
ב ו	o PERI	CARDI	AL	IAINE	0 N 4 D 8		~ wows
,	PART II. Other aignificent conditions contributing to death	but not resulting in	the underlyin	g ceuse given in Pa	rt I. 24a. WAS AN AU		24b. WERE AUTOPSY FINDINGS
3					PERFORME	D?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
ב ב					1 🗆 YES 2 🦎	NO	OF DEATH?
Ξ							1 TES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1 % Inpetient 2 ER/Outpetient 3 DOA OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 X YES 2 NO 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 265. TIME OF INJURY 26c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending Investigation 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 3 Suicide 6 Could not be determined 4 Homicide

29e. CERTIFIER
(Check only one)

The CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the ceuse(s) end manner as stated.

The CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the ceuse(s) end manner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

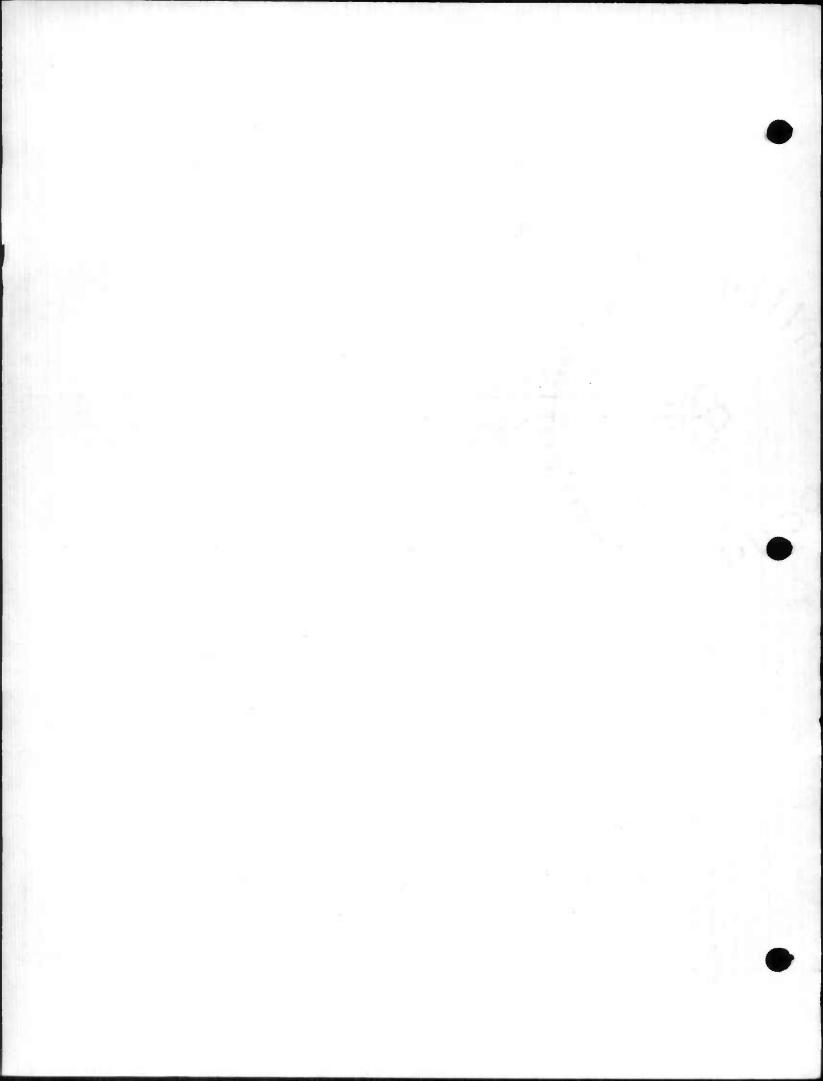
P1170

Howlen M.D. 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

HOSFITAL, 900 CATON AVE, BALTIMURE FLORIN MICULESCU ST. AGHES 31. DATE FILED (Month, Day, Ybar) NOV 2 5 1997

32. REGISTRAR'S SIDNATURE
JUNE DANGES PANDELL

NOVEMBER, 1, 1993



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death B. CONWAY Dey Month Year PINKIE NOVEMBER 21 10:35 AM 4a. Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTOWN BALTIMORE NORTHWEST 4 OSPITAL CENTER 7. Aga (In yrs. last birthday) If Under 1 Yaar if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthpiaca (State or Foreign Country) 1□M 200 F 18 225-20-9805 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. inside City Limits Md 1 Yas 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3505 , S.A. ag Lane 12. Was Decedent Ever in U,S. Armed Forcas? 1 Yes 2000 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Biack, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No Black Specify: 3 ☑ Widowed 4 □ Divorced Yaar or Detas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collage (1-4or 5+) etitian (Oth grade NH 17, Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Kobert Inomas Mannie 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 30601 - Nephew Northcrist Ga 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Ramovai from State 4 ☐ Donetion 5 ☐ Other (Specify) Memoria 21. Signature of Fundrai Service Licenses 21215 IF, H. Wes. 1300 Makash Dallo Mil 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, book, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death immediate Cause (Final diseasa or condition resulting in death) OA INTRACRANIAL BLEED 10 Due to (or as a consequence of) Sequantially list conditions, if any, leading to immediate cause. Enter Undarfying Cause (Diseasa or Injury that initiated events resulting in daath) Last Dua to (or as a consequence of) Due to (or as s consequance of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 9 Unknown PERTENSION 24b. Wera sutopsy findings sysilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

death

Baitimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

after death.

Director: After this cartifications

Vitnit 24 hours
To the Fundral
completely filled

7 is marked other than "natural", or items 23s or 28s-f short traumstic event, the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filted with Department of Health and Mental Hygien, important: if Itam 27 is marked other the any Injury or other trearmetic event, the SDRs.

Funeral

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attending physician and for usa as the burial-transit signed by the a been si funarai

Physician/Medical à Completed 2

Examiner Certification:

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

Hospitai:

25. Was case rafarred to medical

1□ Yes 2P No

27. Manner of Death 1 Neturai 5 Pending investigation 2 Accident

3 Suicide 6 Could not ba 4 - Homicide

28a. Date of injury (Month, Day Yaar)

1 ☑Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of 28c. injury et Work?

1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

281. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify)

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signatura and title of certifiar K.S.RAO.FID

29c. License number 43462

29d. Date signed (Month, Day, Year) NOVENBER 2197

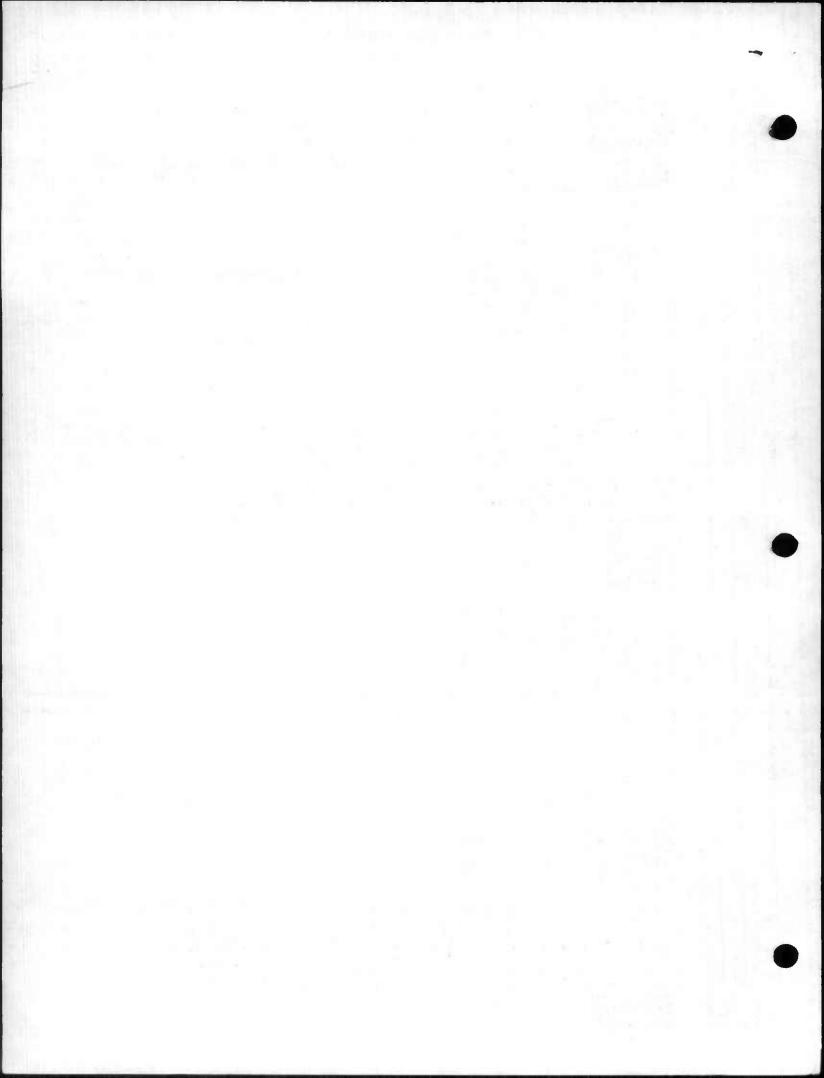
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \ . S . R A O · M · O . RANDALLSTOWN MORTHWEST CENTER

31. Date filed (Month, Day, Year) NOV 2 5 1997 NOV 25



State Registrar

Medical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth MICHAEL CIBULA NOVEMBER 19 1997 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 10659 5. Social Sacurity Number SHELLDRAKE CIRCLE DAMASCUS MONTGOMER If Under 1 Yaer | If Under 24 Hrs. 9. Birthplece (State or Foreign Country) 6. Sex 1 M 2 □ F 7. Aga (In yrs. lest birthdey) Days Months Hours 201-12-428 Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2□No MONTGOMEN AMASCUS 10g. Citizen of Whet Country? DRAKE 1005 20872 12. Wes Decedent Ever in U,S. Armed Forces? 1 LYYes 2 □ No LYYes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Maritel Stetus 1 Naver Marriad 2 Married 1□Yes 2 No Specify: 3 ☐ Widowed 4 Divorced WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) SELF-EMPLONED 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Meiden Sumema) CIBULA HOLAS OLOSTIAK 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) 20872 CIBULA CIRCLE AMES 20a. Method of Disposition Burlel 2 Cremetion 3 Removel from State BERNARD 21. Signature of Fungal Service Licensee 23a. Part1. Enter the disease or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart feiture. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in deeth) Brain 1 YEMR tumor Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10e. Steta

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner result be notified at

7 is marked other traumatic event,

other

0 Department of Important: If any injury or

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23s or

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

of Vital

Division

Funeral Director

Be Completed by

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Physician/Medical Examiner the **USB BS**

I or Attanding Physician: The law requires that the death certificate be estated death.

Director: After this certificate hes been signed by the ettending physician a s certificate has been signed by the ette director, page 2 should be detached for completely filled in by the funeral

To the Hospital within 24 hours a To the Funeral C State

Be Completed by Certification: To

25. Wes cese referred to medical 1 ☐ Yes 2 No 27. Manner of Deeth

29e. Certifier

(Check only one)

29b. Signetura and title of certifier

Medical

5 Pending Investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

111 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner es steted.

Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 ☐ Yas

26. Piece of Deeth (Check only one)

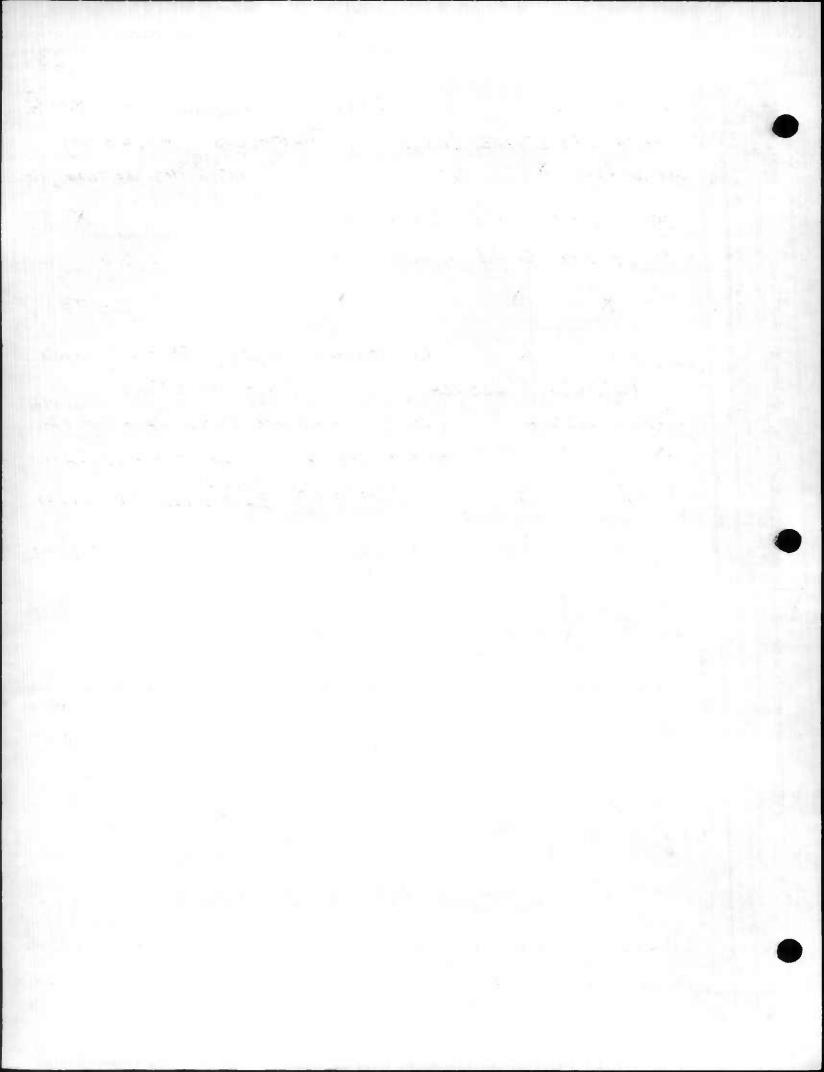
28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) and menner stated.

1 Yes 2 No

30. Name end eddress of person who completed causa of deeth (Item 23e) (Type, Print)

HUDHUD, mo POI TOLLHOUSE AVE, BUILDING E-1, Frederick im) 21701 32 Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4.15 AM Frank W. Chase November 23, 1997 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Heritage Nursing Center Dundalk Baltimore 6. Sex 1X M 2 ☐ F If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Yrs. 219-01-2384 78 02/14/1919 Maryland Usuai Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits Maryland Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2048 Bank Street 21231 USA 12. Was Decedent Ever in U,S. Armed Forces? ↑ ★ Services 2 □ No if Yes, Give Yeer or Detes: ₩₩ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√No Specify: Specify: White 3XXWidowed 4 □ Divorced WW II 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade com 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Brick Layer Steel 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cichocki Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Cichocki / Son 2048 Bank Street Baltimore, Maryland 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 11/26/97 Baltimore, Maryland 21. Signattith of Funeral Servi 22. Name and Address of Facility David J. Weber Funeral Home 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximate Approximate Interval Between Onset and Death CARDIO PULMONARY ARREST Immediate Cause (Final disease or condition resulting in death) METASTATIC BRAIN CARCINOMA Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest EREBROVASCULAR ACUDIENT Due to (or as a consequence of): RIGHT HEMIPARESIS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SEIZURE DISORDER 1 Yee 2 No 3 Probably 4 Onknown MYPERTEMSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No

Physician/Medical Examiner P.O. Records, Completed Aftar this certificate Division of Vital Be 10

Physician

/Medicai

Examiner

Director

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Completed

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Funeral

Director

Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, its Moulcal Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than "rany injury or other traumatic avenual."

Physician

/Medical

Examiner

the Maryland

death with

72 hours after

Baltimore, Maryland 21215-0020

Certification: Medical

2 Accident

3 Suicide

4 Homicide

(Check only

To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this certifica completely filled in by the funeral director; g

State Registrar

29b. Signetyre and fitte of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

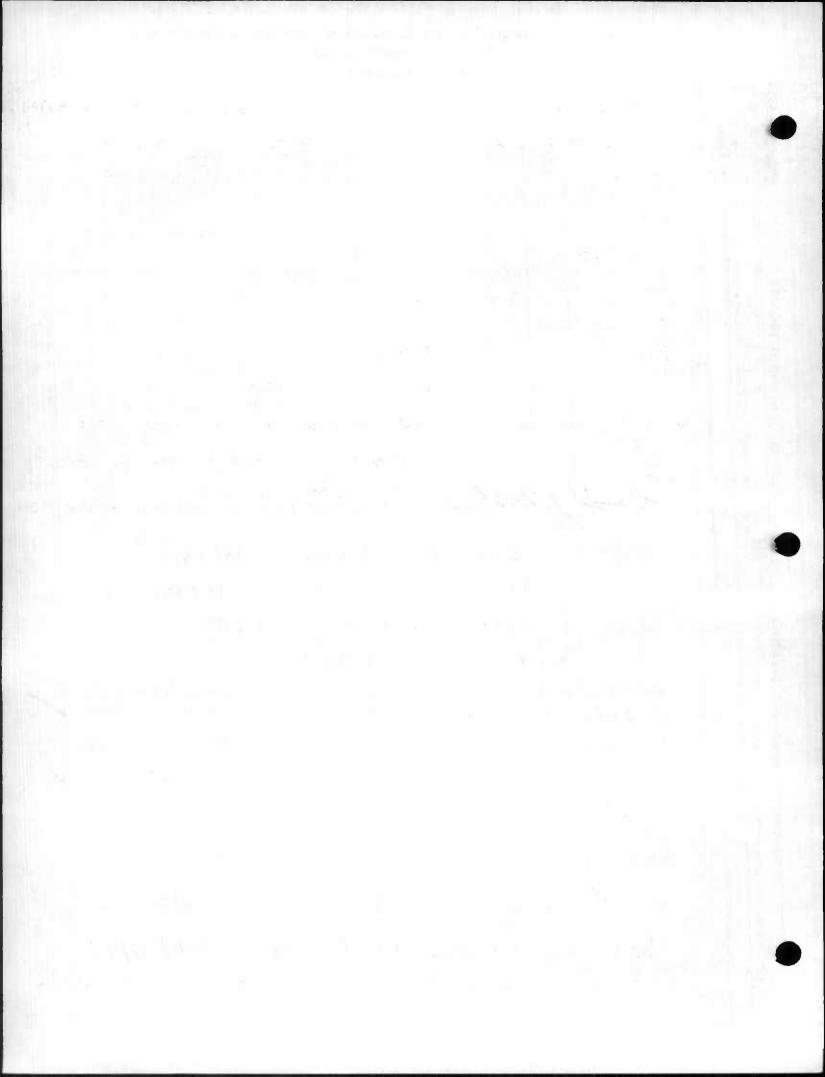
2 Marlet-Place Baltinue MD 21222

31. Date filed (Month, Day, Year) NOV 25 1997

6 Could not be determined

32. Registrar's Signature Hegistrar's Signature

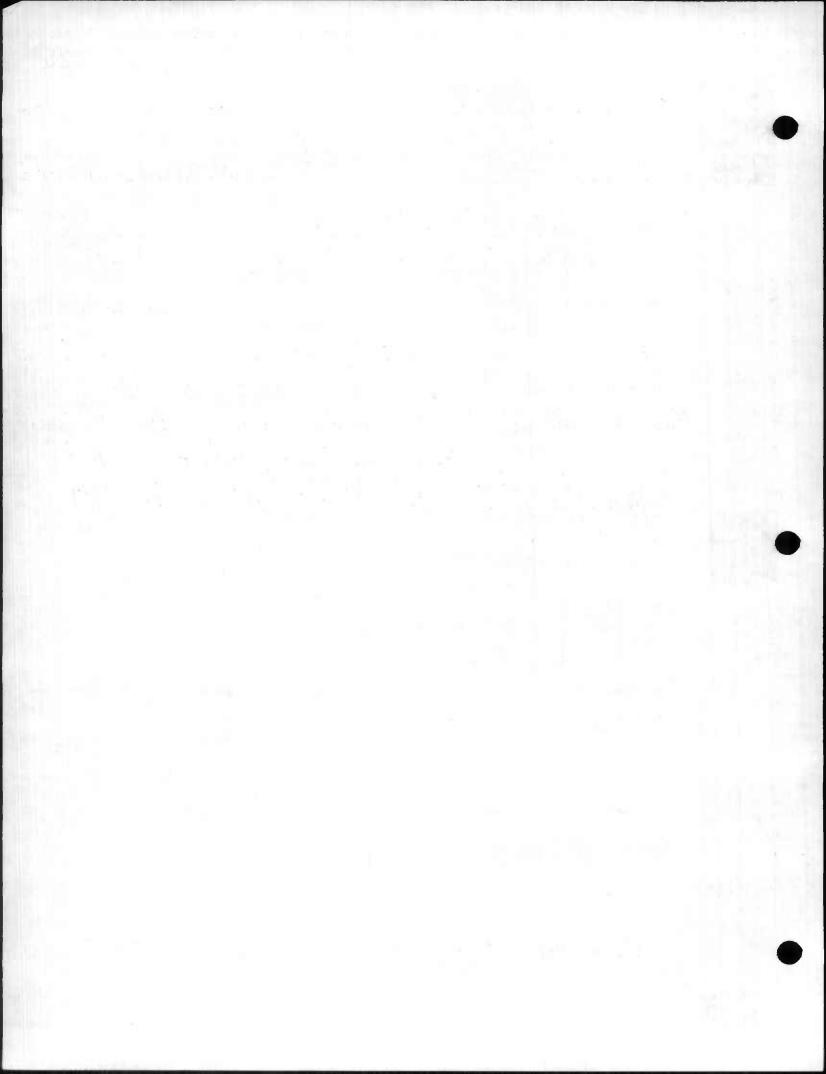
28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify)



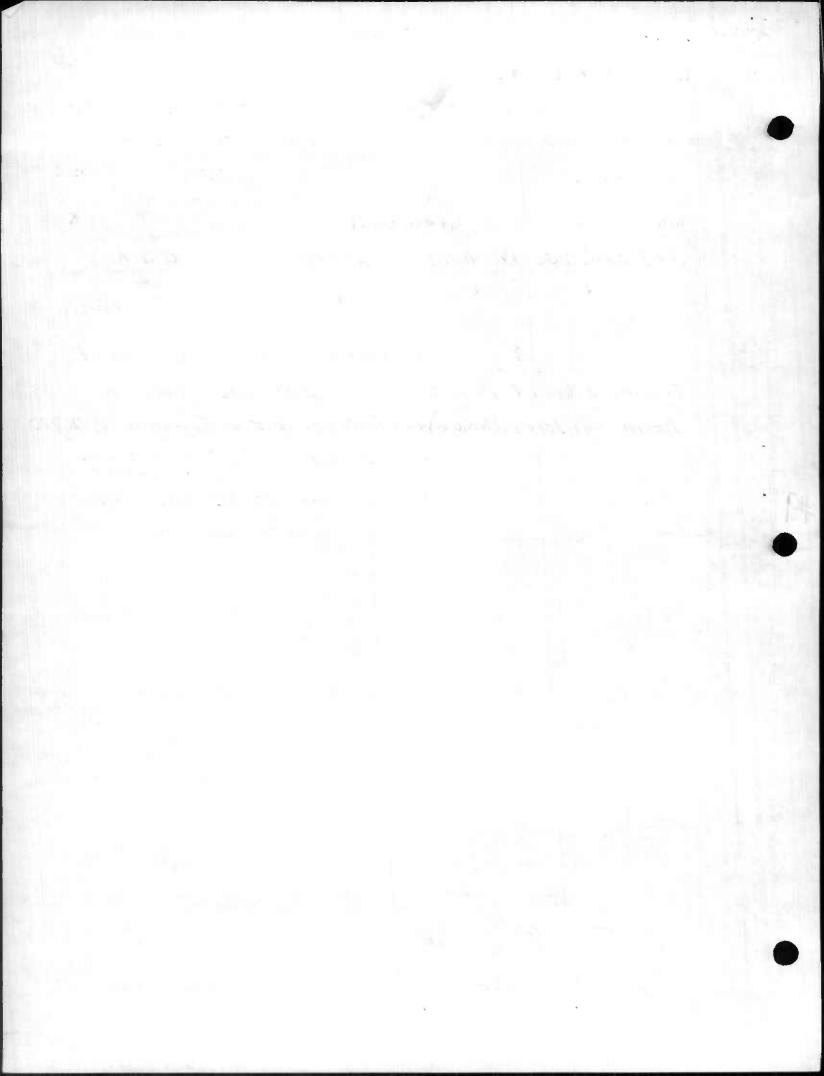
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			otate of Maryland	Certificate o			. No.	35525
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		5. Sociel Security Number 6. Se				9 Date of Bidh	Bulti	
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and Mental a marked o	10	James	3, 1 MOMO	15	D.	25514	2 1	Marks
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Affection Physician: The law requires that the death, ar death, ard cash, ard cash. •ctor: Affer this certificate has been signed by the attenty the funeral director, page 2 should be detached for u.	cati	2 ☐ Accident invastigation 3 ☐ Suicide 6 ☐ Could not be			☐ Yas 2 ☐ No			
iffer d	E	4 Homicida datarmined	28e. Plece of Injury - At homa, building, atc. (Specify)	farm, straat, factory, offic	a	28f. Location (Strain City or Town, 1	at a <i>nd N</i> um <i>bei</i> Steta)	r or Rural Route Number
ours a	ပ္	On Coding						
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical Certification:	29a. Certifiar 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the bast of my knowled nar: On the basis of examination end manner stated.	ga, gaatn occurred at tha and/or invastigati <i>on</i> , in my	tima, data and place opinion, daath occur	rad at tha tima, date	sa(s) and man a and piace, ar	nar as statad. nd dua to tha causa(s)
within 2 To the comple	Me	29b. Signatura and titla of certifier	end marinal stated.	29c. Lica	nsa number	29d	. Data signed	(Month, Dey, Year)
- s - o		10000	as Mo	Aco	1400301			lou 20,19
4		30. Nama and address of person who co	omplated cause of death (Item 23)) (Type, Print)	1402321. of Balt	USYSDY	70	00 00,17
		0 1		ospital a	of Balt	Share		
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DHMH 16 Rev 6/95



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5	Funeral	11. Maritel Statu		12. Was Decedent Armed Forces	?	S. 13. Wes De It Yes, s	cedent of F pecify Cub	łispenic Origin? (en, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Ra Bio	ca - Americ eck, White,	etc.
arrain .	Dy F		arried 2 % Married d 4 □ Divorced	If Yes, Give	No	1 ☐ Yes	2 No	Specify:		Speci	ity: 01	0-11
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r other		20e. Method of I			20b. Pla	aca of Disposition (formetery, cremetory)	Verne of or other ple	ce)	Dete	20c. Location	- City or To	own, Stete
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97-6771-510 B.K.S.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere 7 35527

29d. Date aigned (Month, Day, Year)

NOV. 23, 1997

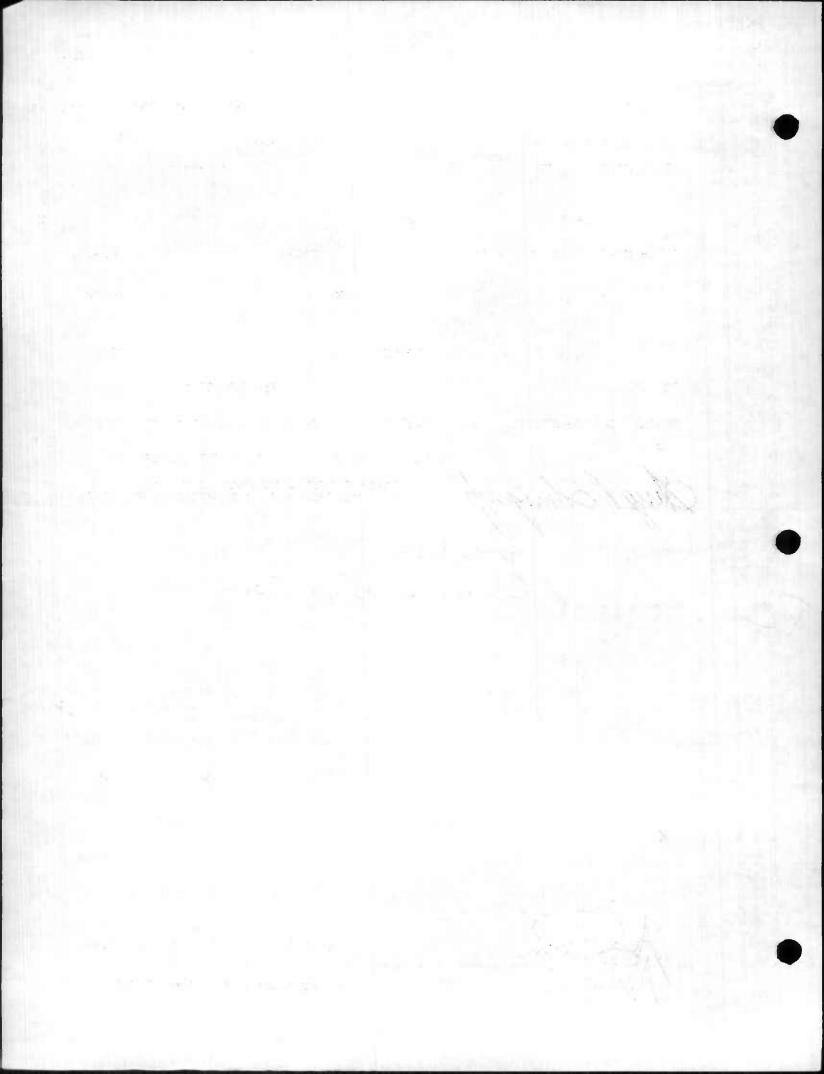
		1. Decedent's No	ame (First, Middle, I	act)		_	Certif			Doutt		2. Date of De	Reg. N	NO.		3. Time of Death
icia	_	COY COL										Month NOV.	0	Day 2, 199	Year	1:13 PM
dic nin		4a. Facility Name	e (If not institution, g	ive street end n	um <i>ber)</i>				4	b. City, To	wn, or Lo	ocation of Death 4c. County of Dea				7.70 111
	61	6524 CLEVELAND AVENUE BALTIMO								IMOR	E		1	N/A		
ai or		5. Social Security 342-34-2		Sex XXM 2□F		n yrs. last birti		Under 1	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 09/23/	194	1	9. Birthplace Country)	e (State or Foreign
		Usual Residence														
1	_	10a. State	10b. County		10	Dc. City, Town		on								Inside City Limits
5-UUZU 72 hours attar death with the Maryland naturel*, or items 23a or 28a-f show	Funeral Director	IL 10e. Street and N	LAKE			2	ZION 10f. Zip Code					10g. Citizen of What			1 ☐ Yes 2 ☐ No	
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	by	3 D Widowed	4 Divorced	If Yes, G Year or	If Yes, Give Year or Dates:			1 ☐ Yes ŽŒNo Specify:						Specify	y: WHITE	2
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29b. Signerure and title of certifier

111 Penn Street, Baltimore, Maryland 21201

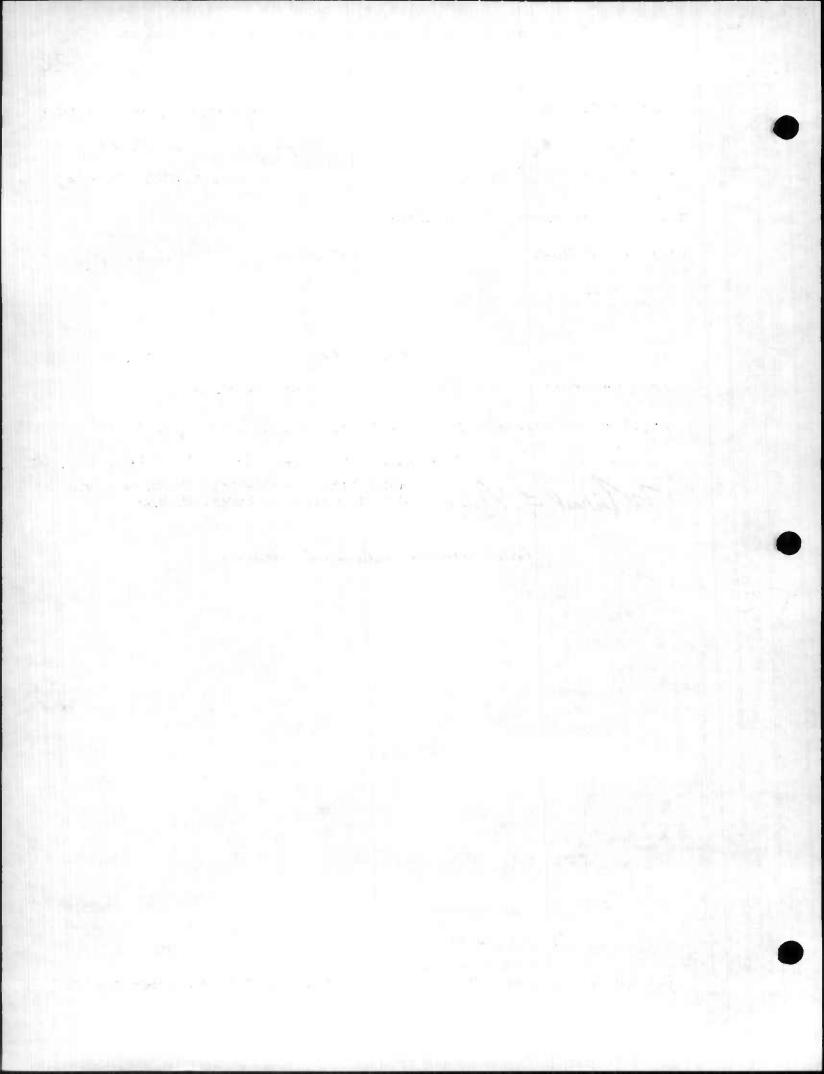
impleted cause of death (Item 23s) (Type, Print)

29c. License number O.C.M.E



	1. Decedent's Name (First, Middle, Last)							Death	2. Date of I	Reg. No.	- '		528 Time of Death
an								Month	Day		ear		
cal ier	4	e. Facility Name	NOVEMB or Location of Dec		1997 County of I		:15A.M						
		012 ORMAND ROAD DUNDALK								BALTIMORE			
	1	5. Social Security		. Sex 1 □ M 2√2 F		In yrs. last birth	nday) If Under 1 Ye Months Day		lin. 8. Date of E (Month, I	Birth Day, Year)	9. Birthplece (Stell Country)		(Stele or Fore
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Director	1	Md.		imore		Dunda	1k					1	☐ Yes 2 🟋
Dir		10e. Street and N	Number rmand Re	2 2			10f. Zip Code				10g. Citizen of Wh		
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by Fun		1 Never Ma	arried XXMarried	Armed 1 Ye If Yes,	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		If Yes, specify C		erto Rican, etc.)		Black, \	White, etc.	
			15. Decedent's	Education			Decedent's Usual Occ	upation		16b. Kind	d of Busin	ness/Industry	,
Completed			econdery (0-12)		de completed) College (1-4or 5+)		'Give kind of work doi life. DO NOT use ret			16b. Kind of		f Business/Industry	
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 35529 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day 22,1997 Patricia Delores Cross November 12:25 p 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 3800 Old Columbia Pike Ellicott City Howard County If Under 1 Yaar If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) May 27, 1942 9. Birthplace (State or Foreign 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Months Days 1□M 2□E Maryland 214-44-0419 55 Yrs Usual Rasidence of Dacedant 10b. County 10c. City. Town or Location 10d. Insida City Limits Baltimore County Maryland Catonsville 1 Yas 2 No 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 6412 Craigmont Road 21207 USA 12. Was Decedant Evar In U,S. Armed Forcas? 14. Race - American Indian, Black, White, atc. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2X No If Yes, Giva Yaar or Datas: XXXX Navar Married 2 Married 1 Yas 2X No Specify: Specif Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Registered Nurse Hospital 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Ambrose David Cross Gladys M. Stanton 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Ms. Gladys Cross/mother 3800 Old Columbia Pike, Ellicott City, MD 21043 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 26NOV97 Marriottsville, MD 4 Donation 5 Othar (Specify) Crestlawn Memorial Gdn. 21. Signature of Funeral Seeding Licensee 22. Nama and Addrass of Facility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 . Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or, or heart failure. List only one cause on each line. Approximate tritervat Between Onset and Death ediata Causa (Final di aasa or condition r sulting in death) Due to (or as a consequance of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or tnjury that initiated events rasulting in daath) Last Due to (or as a consequence of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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10a. Stata

Funeral

Director

7 is marked other than "natural", or items 23e or 28a-f ehow traumetic event, the Mod cal Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after teppertment of Heelth and Mental Hygiene. Important: If Item 27 is merked other than "natural", or iter eny Injury or other traumetic event, the Medical Examination.

Baltimore, Maryland 21215-0020

the Maryland

with

death

Examiner physician s the buriel Division of Vital Records, P.O. Box 68760 Physician/Medical 98 guip use etten ò signed by the t by Completed peen

hes page 2 certificate To the Hospital or Attending Physiolen: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 2 Certification: Medical

0

State

29b. Signature and title of certifier 1065 Ptu xut Parkway

25. Was cese refarred to medical

1 Yas 2 No

Hospitai:

5 Panding Invastigation

6 Could not be detarmined

28a. Data of Injury (Month, Day Year)

axaminar?

27. Manner of Death

1 Natural

2 Accidant

3 ☐ Suicida

29a. Certifiar

4 Homicida

(Check only

22-Registrar's Signatura ulik Davidson

1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA

28a. Piace of Injury - At homa, farm, straet, factory, office building, atc. (Specify)

28b. Tima of

28c. Injury at Work?

29c. Licansa number

1411

1 ☐ Yas 2 ☐ No

1 Yas 2 XNO 1 Yas 20 No

26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify)

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated.

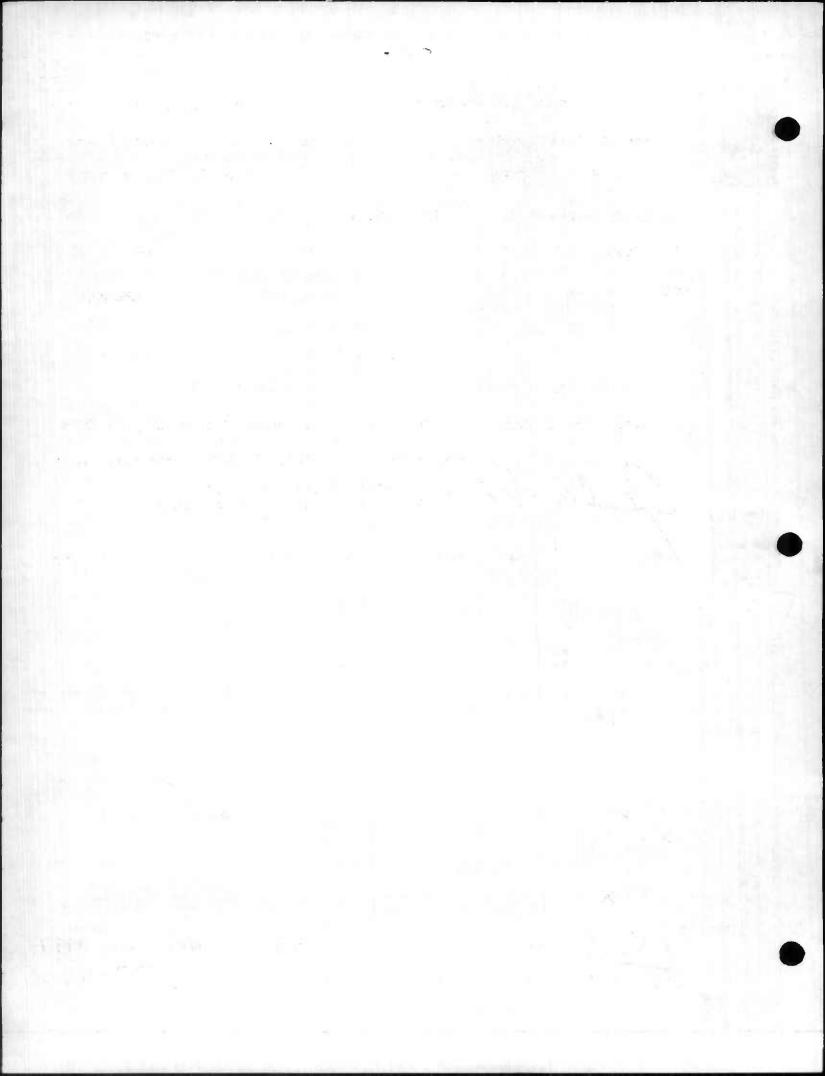
Madical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

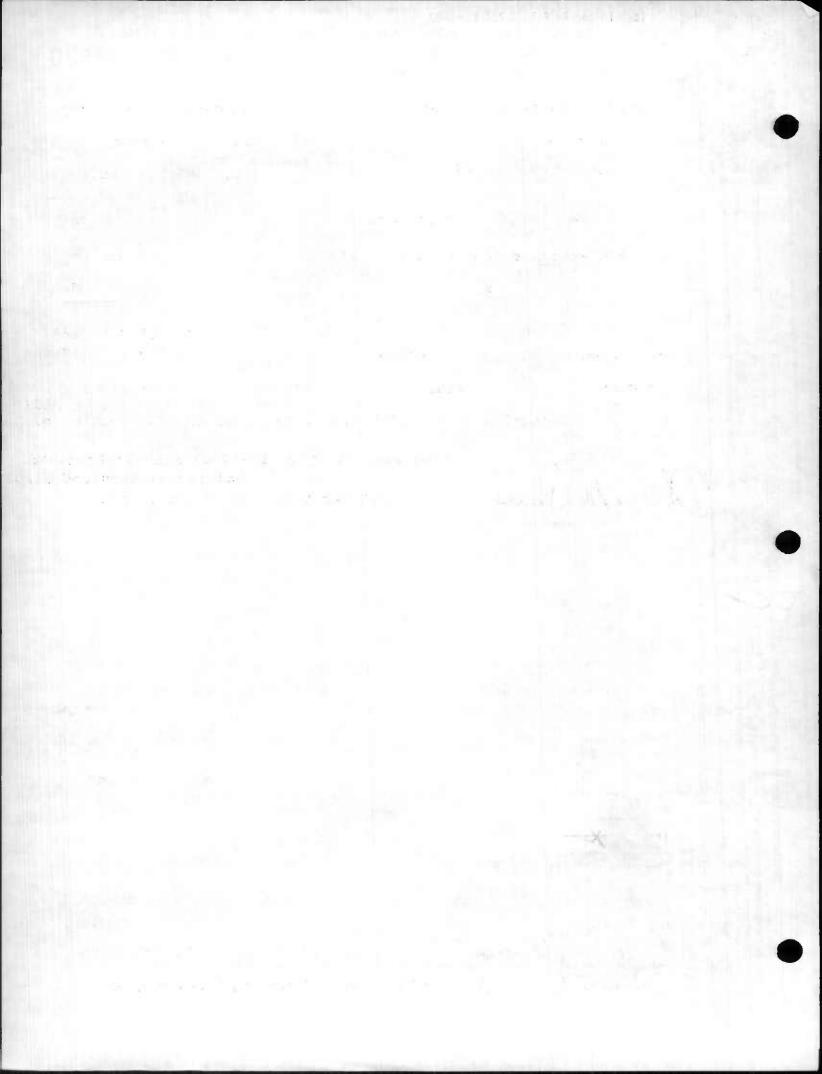
Nev,

Columbia.

31. Data filed (Month, Day, Year) Registrar

DHMH 16 Rev 6/95





/Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

7 is marked other than "natural", or itsma 23a or 28a-f show traumatic event, one Madical Examinar count to motified at

"natural", or

the Meryland

72 hours after

filed within 7 Hygiene.

permit. Pages 1 and 2 should be filed withit Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment.

Physician

Baltimore, Maryland 21215-0020

the 88 ettending p been signed by the should be deteched has director, page 2 After this certificate Hospital or Attending Physician: 24 hours efter deeth. Director: /

Physician/Medical þ Completed Be To Medical Certification:

certificate be executed buriel-tran and Box 68760, P.O. Records. of Vital Division

Cullen

within 2

31. Data filed (Month, Day, Year) State 2 5 199 Registrar

29b. Signature and that of certifiar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case rafarrad to medical 1 Yas 2 No 27. Mannar of Death 1 Natural 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homiclda 12 Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data end place, and dua to tha causa(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at tha time, deta and place, and dua to the cause(s) 29e. Certifian

and manner steted. 29c. License number 29d. Deta signed (Month, Day, Year) hods

D 15504

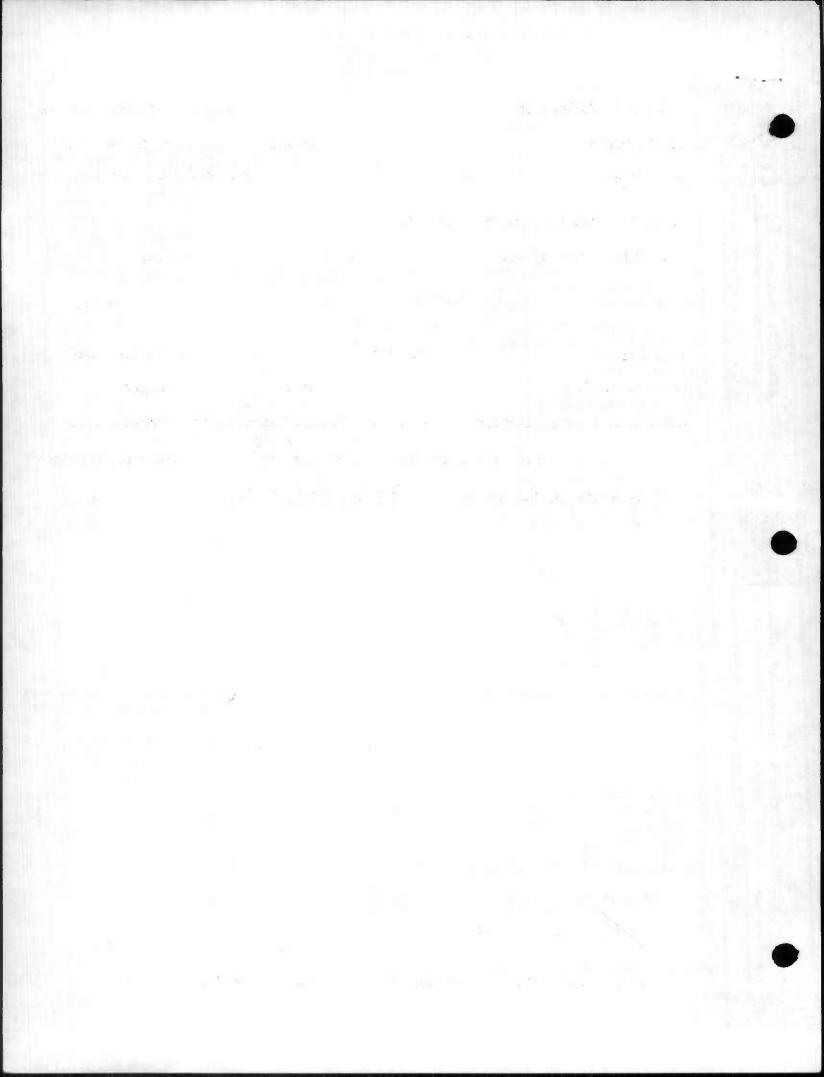
20

30. Name and eddrass of parson who complated causa of death (Item 23a) (Type, Print) Eddie Nakhuda, M.D.

2300 Dulaney Valley Rd

Timonium, Md 21093

32: Redistrer's Signature



					Cert	tificate of	Death		Reg. No.			
Physician		1. Decedent's Nama (First, Middla, La	st)	1000			7	2. Data of D		Yeer	3. Tima o	f Deat
Physician Medical/	-	JOHN JOSE	PH I	DILLER	2		N	OVEMBE		997	7:10	PN
Examiner	-	4a. Facility Nama (If not institution, giv	a street and number	r)			4b. City, Town, o	r Location of Dea	th 4c. County	of Death		
	ı	Saint Joseph	Medical	Cente	5 L		Tows	on	E	Balti	more	
nerai ector		5. Social Security Number 6. S 214 05 3483 Usual Rasidance of Dacedant	Sex 7. A DSQM 2□F	Aga (In yrs. las	st birthday) Yrs.	Months Deys				9. Birthp Cour NAR	place (Steta htry) LA CD	or For
M 10		10a. Stata 10b. County		10c. City,	Town or Loc	ation				1	Od. Inside C	Ity Lin
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nt, tre Hearen Ex.		15. Decedent's En (Spacify only highast gra	ducation ada complatad)		16a. Deceda (Giva k	int's Usual Occur ind of work done	pation during most of wed)	orking	16b. Kind of B	usinass/In	dustry	
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other traumatic event, tra	5	17. Fether's Nema (First, Middle, Last,	DILLER				18. Mother's N		a, Maidan Sumar			
3 P	2	DIORGE		ANNA	CATHSA	ins tri	13CH	5				
E E E		19a. Informent's Nama/Ralationship (Type, Print)		19b. Meiling	Address (Stree	t and Number or	Rural Routa Num	ber, City or Town	, Stete, Zip	Code) 15	99%
item 27 other tr	1	HOWARD E. PHILL	RS		38 Ho		= S DRIV	2 PiT	BOURGH	1, ten	relyer	Nik
		20e. Mathod of Disposition	10	cen	ce of Disposinatary, crama	ition (Nama of atory or other pic	BCe)	Data Nov.24	20c. Location	- City or To	own, Stata	
7		1 Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Othar (Specif		a		PEMOR		1990	PARKVI	115 (PARVI	Ac
Important: If any injury or pncs.		21. Signature of Funaral Service Licer	nsea /	11.1011		Name and Addr	1		Riss	200-1	31	7 7
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	+	23a Part Enter the disease or com	She state that advan	ad the death		800 HE	1RTORO	MOAD	LAKKA	12/	IBRATE	Inc
lcian dical		23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only Immediata Causa (Final	d		DO NOT AME	tha mode of dy	nig, such es card	ac or respiretory	errest,	1	Approxime Interval Be Onset and	Deet
miner		disease or condition resulting in death)	PNEUMC	2 10 170	es a consequ	anca of):					15 D	HY
sit line			b. —							1		
attending physician and for use as the burial-transit claryMedical Examiner	Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury C											
se es the bur	C. — Cause (Disaasa or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence of):											
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or us	d								1			
latached for us	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								ntributa to	the causa	of de	
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5 2		axaminer? 1 ☐ Yas 2 █ No	Hospital: 1X Inpat	tiant 2 F	R/Outpatient	3□ DOA O	her		sidence 8 Oth	er (Spacii	(v)	
		27. Mannar of Deeth	28a, Data of In	jury 2	8b. Time of	28c. Inju			how Injury occur		**	
e fune ation		1 Natural 5 ☐ Panding 2 ☐ Accidant invastigation	(Month, D	ay rodi)	Injury		Yas 2□No					
itery filled in by the funeralical Certification:		3 Sulcida 6 Could not b 4 Homicide determined	286. Piece of it	njury - At hom etc. (Specify)	a, farm, stree	at, factory, office	(i		(Street and Numi	ber or Rura	al Routa Nur	nber,
cai		29a. Certifier Certifying Ph (Check only one) 2 Madical Exam	ysician: To the best niner: On the basis and manner s	t of my knowle of axaminetio stated.	edga, death on and/or inva	occurrad at tha t astigation, in my	ima, data and ple opinion, daath oc	pe, end due to the curred et the time	a ceusa(s) and m	annar as s and dua to	tated. tha cause(s)
Medi		29b. Signature end titla of certifiar				29c. Lican	se number		29d. Data signe	ed (Month.	Day, Year)	
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	_	- O A	~		,		D41410	34	0 1 0 10 10 10 10 10 10 10 10 10 10 10 1		, , , ,	
	1	30. Name and eddress of person who	complated causa of	death (Itam 2	(Type, P	rint)						
		JOGINDER P. ME	HTA. M. I).	7620	YORK	ROAD, T	OWSON.	MARYLE	ND_a	21204	
		31 Data filed (Month Day Year)	20 Decisi	tearly Cilliantin	100	4 -	7					

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Barty S. T.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Devine 8:41 40 Nevember 21 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Johns Hopkins Bayview Hedical Contar | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | July 11, 1921 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthpiaca (Stete or Foreign Country) **Funeral** 1 M 2□ F Maryland Yrs. 219-05-8321 76 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examinat must be not ited at 1 X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3325 Richmond Avenue 21213 U. S. A. Funeral 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item ony injury or other traumatic event, the Medical Exercises once. 1 X Yas 2 No If Yes, Give Year or Dates: WW II 1 Never Marriad 2 X Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Crown Cork & Seal 8th Grade Lithographer 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John T. Devine Florence Burke 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) Hedi K. Devine (Wife) 3325 Richmond Avenue, Baltimore, Maryland 21213 20b. Plece of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith 11/24/97 Baltimore, Maryland 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

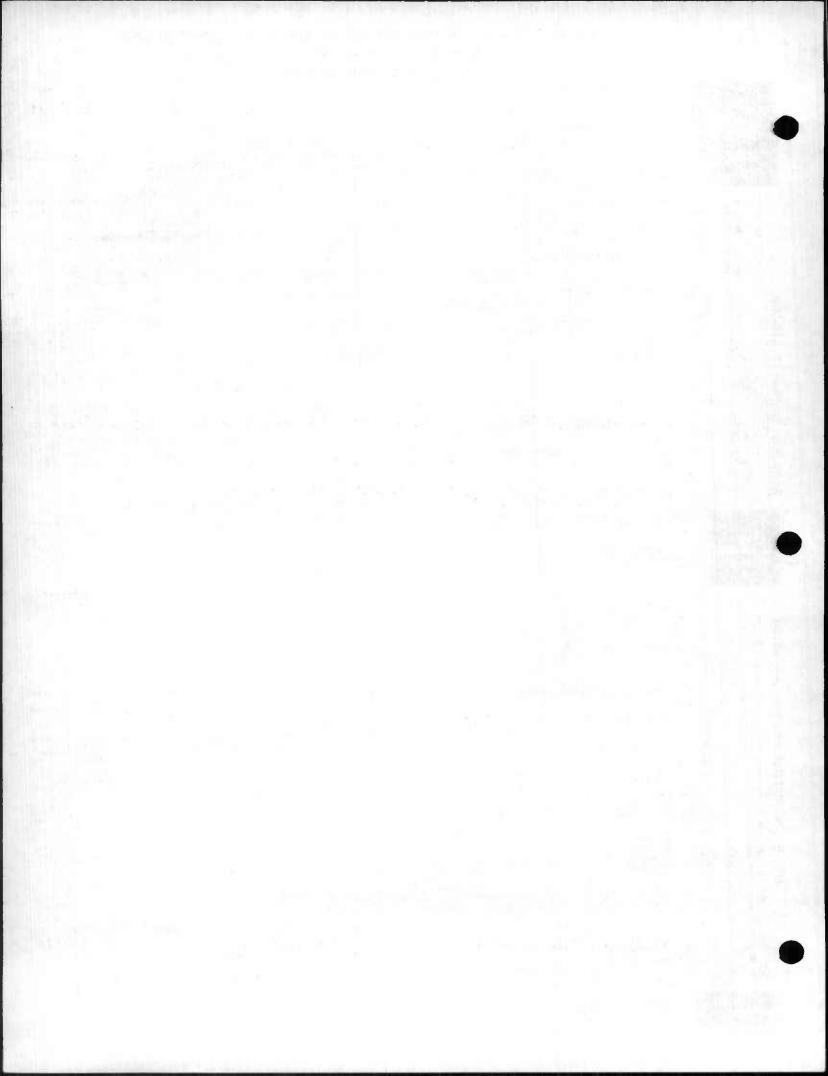
Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate intervel Between Onset and Death **Physician** /Medical Immadiate Cause (Final a. Acute renal failure 35 days disease or condition resulting in death) Examiner Examiner physicien and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part it. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 No 3 Probably 4 Unknown Chronic venal insufficiency Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Diabetes Previous After this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yes 2 No 2 To the Hospital of Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Invastigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Medical 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and plece, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Molf Edilman MD JHH - N3303 November 21, 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holly R Dohlmon, MD; Tower 110; The Johns Hopkins Hospital 32. Ragistrar's Signature 31. Date filed (Month, Day, Year) NOV 2 5 1997 State Registrar he rundson-Randell

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State of Maryland / D

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Department of Health and Mer	ntal Hygiene / 3555	L
Certificate of Death	Peg No	

DAVIS **Physician** /Medical

1. Decedent's Neme (First, Middle, Last)

SHOCK TRAUMA CENTER

DAVIS

2. Dete of Deeth NOVEMBER 20, 1997 3. Time of Deeth

Examiner

BERNARD 4a. Facility Neme (If not institution, give street and number)

4b. City, Town, or Location of Deeth

BALTIMORE

8:48P.M. 4c. County of Deeth

Funerai Director

> 28a-f show must be notified

6

items 23a

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"natural"

Hygiene.

other !

permit. Pages 1 and 2 Depertment of Health a important: if Item 27 is any injury or other tra once.

Physician

Examiner

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within 24 hours after deet To the Funeral Director:

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Completed

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Certification:

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certificate

The law requires that the death

or Attending Physician:

the Hospitai

traumatic

the Medical Examiner

Marylend

filed within 72 hours after

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Pages 1 and 2 should

21215-0020

Maryland

Baltimore,

68760.

Box

P.O.

Division of Vital Records,

5. Social Security Number 219-88-7236 Usuel Residence of Decedent

7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 1 M 2 □ F 20 Yrs.

If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year, Devs

N/A 9. Birthplece (State or Foreign JUNE 07,1977 MARYLAND

Funeral Director

by

Completed

Be

0

10a. Stete

10c. City, Town or Location

BALTIHORE

10d. Inside City Limits 1X Yes 2 No

MARYLAND 10e. Street end Number

CHESTNUT 509 HILL AVENUE

NIA

13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

USA. Race - American Indien, Bleck, White, etc.

1 Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Yeer or Detes:

1 Yes 2 No Specify:

Specify: BLACK

15. Decadent's Education (Specify only highest grade completed) ementary/Secondery (0-t2)

10b County

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

10g. Citizen of What Country?

11+HGRADE 17. Fether's Neme (First, Middle, Last)

DAVIS

UNEM PLOVED

18. Mother's Neme (First, Middle, Maiden Sumeme)

BERNARD

19a. Informent's Name/Reletionship (Type, Print)

SR.

GLORIA JEAN t9b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

BERNARD DAVIS SR, (FATHER) 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State

20b. Plece of Disposition (Name of cemetery, cremetory or other plece)

1509 CHESTNUT HILL AVE. BALTIMORE, HD. 2/2/8

Pece of Disposition (Name of Dete 20c. Location - City or Town, Stete

4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service License MT, ZION CEMETERY 22. Name and Address of Fecility

11-26-97 LANDSDOWNE, MARYLAND JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTO. HD, 21217

Sharron Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line.

MULTIPLE GUNSHOT WOUNDS

Immediate Ceuse (Final disease or condition resulting in death)

Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury Physician/Medicai thet initieted events resulting in deeth) Last

Due to (or es a consequence of):

Due to (or es e consequence of)

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probabty 4 Unknown

24e. Wes an eutopsy performed?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 Ves 2 □ No 26. Piece of Deeth (Check only one)

1 Yes 2 No

25. Was case referred to medical 1 Yes 2 □ No

1 Inpatient 2 XER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 11. 20- 97

Pert fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i.

28b. Time of Injury 19568

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. fnjury et Work? 1 Yes 2 No

28d. Describe how injury occurred Sussou SI+05

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) STUBET

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1000 BLK HOSTEY ST IS ALTHORE

29a. Certifier (Check only

27. Manner of Deetl

1 Naturel

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

30. Neme end address of person who comple ted cause of deeth (item 23e) (Type, Print)

5 Pending investigation

6 Could not be determined

O.C.M.E.

NOVEMBER 21, 1997

State Registrar

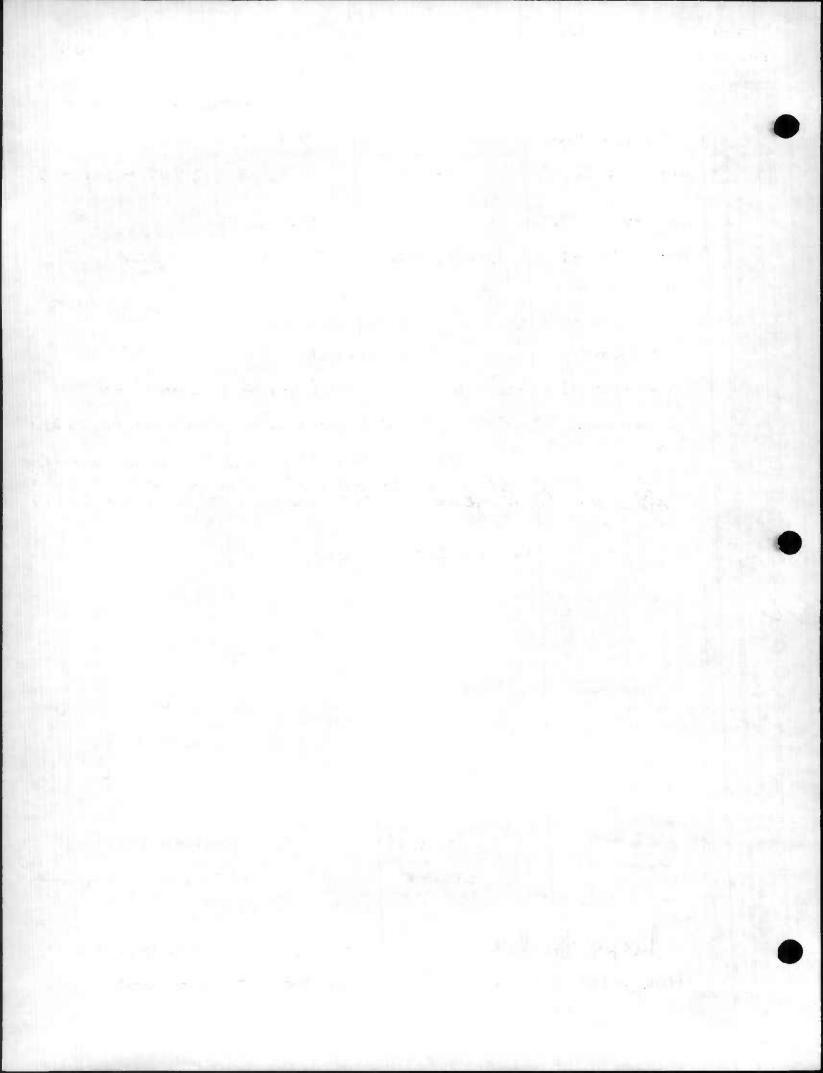
MARGAMON A. KORSU LM.

111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature a Davidson

DHMH 16 Rav 6/95

29c. License number

29d. Dete signed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 4=20AH Month Yeer **Physician** DAVIC OFAINE /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Date of Birth (Month, Day, Ye NO1/S N WING JON Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 213-10-9087 1□M 20 F Deys APRIL 14, 1909 SOUTH CAROLINA Yrs. Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No BALTIMORE Director MARYLAND 10e. Street end Number 10g. Citizen of What Country? 5009 MER AVENUE USA Funeral 11. Marital Status Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Yes 2 No Specify: þ Specify: BLACK 3 10 Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) CARR-LOWERY GLASS CO WORKER KMDERGARDEN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) JAMES UKES JOHNSON LLIZABETH 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA CARTER (COUSIN) 15009 PALMER AVENUE, BALTIHORE, HD. 21215
Date | 20c. Location - City or Town, State 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State ARBUTUS CEMETERY 11-24-97 ARBUTUS, HARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility of Funeral Service Lice BROWN JR. FUNERAL HOME, P.A 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. BALTIHORE, HD. 21217 Approximate Intervel Betw MYOCARDORI INFARCTION Immediate Cause (Finel disease or condition resulting in death) Due to (or es a consequence of): ANENO CA Examiner STATIC Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) GNAL FAILURE Physician/Medicai Due to (or es e consequence of) MICV Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 DUnknown p 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en autopsy performed? Completed 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide

signed by d be detact Records, peed page 2 certificate Division of Vital #

Director

7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Examiner must be notified at

e filed within 72 hours after all Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe eny injury or other traumatic event

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

the Maryland

death

Certification:

Altar death. d or Attend after deatl Director: To the Hospital o within 24 hours at To the Funeral D

edicai 29a. Certifier 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as steted.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as steted.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.

29c. License number

3530

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

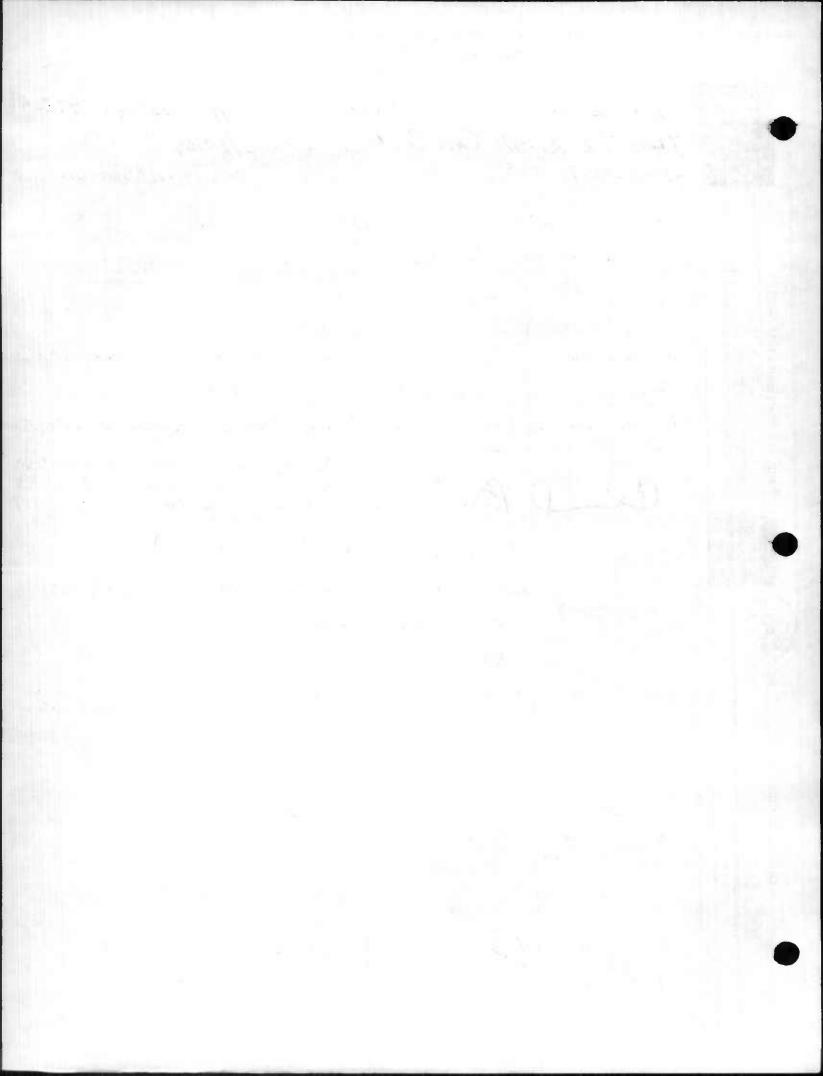
CHATTENTEE 3927 ANNAPOLLS do NO SHAK

31. Dete filed (Month, Day, Year)

Registrar

State

32. Registrar's Signeture Julia Stridon-Randall



Dond 68760 Box signed by the a Narner P.O. Records, page 2 s certificate Vital director. of this Vame eral Director: After this Attending death.

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be nothed at

should be filed within 7. and Mental Hygiene.

. Pages 1 and 2 should be fit then of the Health and Mental Heart: If them 27 is marked oth jury or other traumatic even

permit. Page Department of Important: If any injury or once.

Physician /Medical

Examiner

21215-0020

Baltimore, Maryland

Completed Be To Certification:

edical

4 Homicida

29a. Cartifiar

6 Could not be determined

28e. Place of fnjury - At homa, farm, straat, factory, office building, atc. (Spacify)

7:00

SURGERY

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 900 Caton Ave., Baltimore MD

Hospital Operating Room 1[XCertifying Physician: To the best of my knowledge, daath occurred at tha time, date end place, and due to the ceuse(s) end mannar as steted.
2 Medical Examiner: On the basis of axemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and mannar stated.

29b. Signatura and title of certifiar

D09990

29c. Licansa number

29d. Data signed (Month, Day, Year) November 22, 1997

30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print)

Michael E. Pelczar, M.D., St. Agnes Hospital, 900 Caton Ave., Baltimore, MD 21229 31. Data filed (Month, Day, Year)

State Registrar

NOV 25199



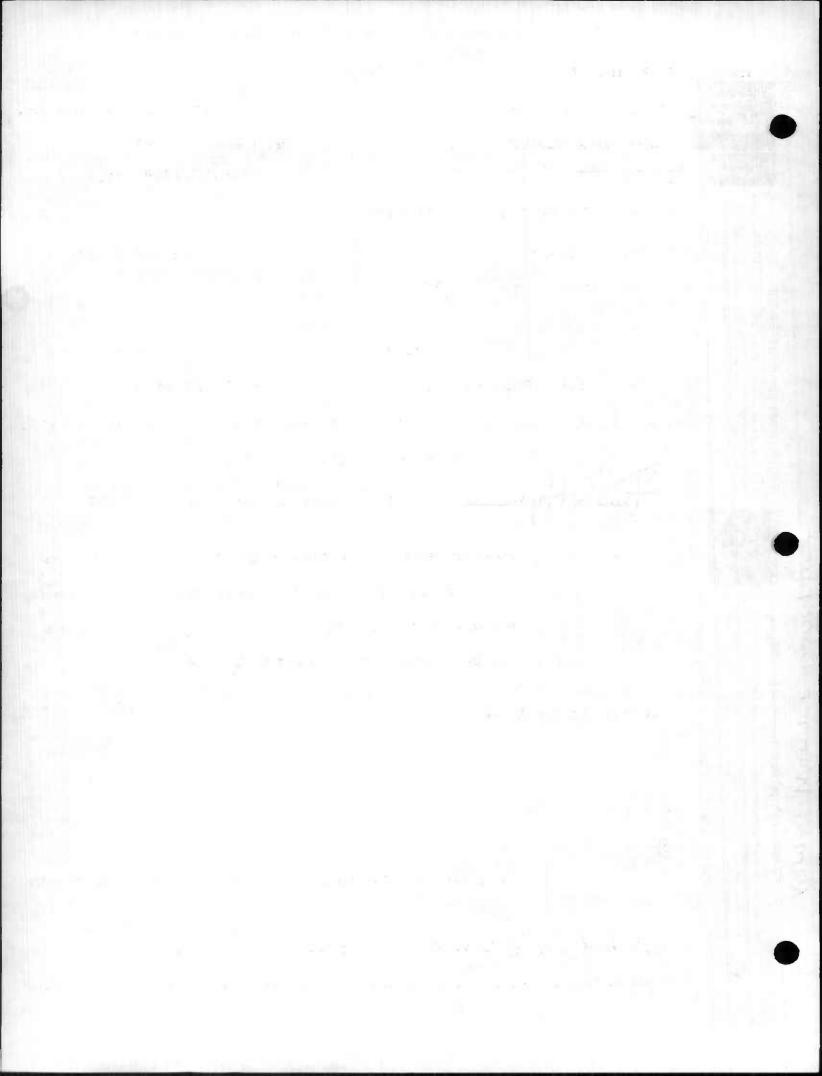
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within 24 hours at To the Funeral Dicompletely filled

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Yourmber /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner ENERAL 14/1/10 Under 24 Hrs. 10 5. Sociel Security Number If Under 1 Year 8. Data of Birth (Month, Dey, Year) Birthpleca (Stete or Foreign Country) 6. Sex 7. Age (In y/s. lest birthday) **Funeral** - 425 1□M 2□F 121-34-425 Usuel Residence of Decedent Yrs. Director 18,1943 10a Stata 10b. County 10c. City_Town or Location 10d. inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examiner mant or notified at NA 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2101 DIVISION 2121 ST U.SA by Funeral Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Merital Status 12. Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene. Att if item 27 is marked other than "natural", or ite into yor other traumatic event, the Modical Eventing my or other traumatic event, the Modical Eventing. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 TNo Specify: BLACK 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementery/Secondary (0-12) College (1-4or 5+) HOUSE WIFE DOMESTIC 17. Fether's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Meidan Sumama) Be RROWN CIEMEN MABLE COOPER 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) NEWOL DIVISION JONES 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny injury or Nov 28, BALTIMORE KING MEM. PARK 4 □ Donetion 5 □ Other (Specify) 21. Signatura of Funerel Service Licenses 22. Nama and Address of Fecility ESTEP Bris. FUNERAL HOME Desus 1300 EUTAW PL 2121 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or hear feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Causa (Diseasa or Injury that initiated events resulting In death) Last Due to (or as a consequence of): be en 68760 or Attending Physician: The law requires that the death certificate the Due to (or as e consequance of): 98 P.O. Box USB jo ate has been signed by the a page 2 should be datached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of causa of death? Be Completed 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No director. 25. Wes cese referred to medical 26. Place of Deeth (Check only one) To the Hospital or Aura Within 24 hours after death. To the Funeral Director: After this communities yilled in by the funeral dir Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending Investigation 1 Yes 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicida 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide

Division of Vital Records.

State Registrar

29b. Signatura and title of certifian

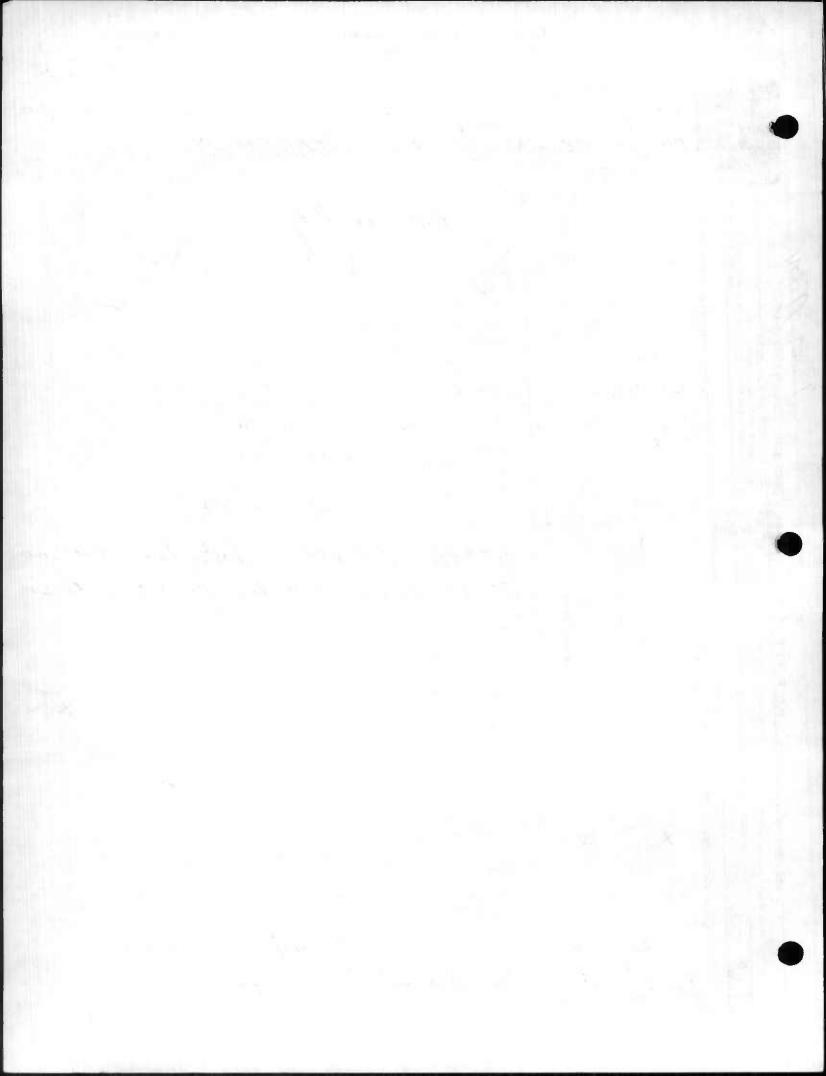
29a. Certifier

29c. Licensa numbar

1 Cartifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner as steted.
2 Madical Exeminar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s)

end manner steted.

29d. Date signed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death ^D22, 1997 **Physician** Month November 1:45 A.M. Stanley Lusby Dodson /Medical 4b. City, Town, or Location of Deeth 4a. Facilify Name (If not institution, give street and number) 4c. County of Death Examiner Hamilton Nursing Center Baltimore City 5. Social Security Number If Under 1 Year if Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Days 1X M 2 F Yrs Director 81 1916 578-12-3813 6, Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumetic event, the Modical Examiner must be notified at Maryland Baltimore County Baltimore 1 TYes 2 TXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Counfry? 31-A Mopec Circle 21236 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, efc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than any Injury or other traumerin according Etementery/Secondary (0-12) 5 Years Teacher School 17. Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Frank Joseph Dodson Daisy Lusby 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda J. Saunders/Daughter 4403 Parkmont Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/26/97 Parkwood Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Servica Licenses 22. Name and Address of Fecility
John C. Miller, Inc. ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, heart failure. List only one cause on each line. 21206 Approximate Intervel Between Onsef end Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last end physician e Box 68760, 80 for use es P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobaced use contribute to the cause of death? signed by 1 Tes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were eutopsy findings eveitable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 hes certificate vision of Vital Attending Physician: Be 25. Was case referred to medical director 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3D DOA this tha funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. injury at Work? After 5 Pending investigation 1- Natural e Höspital or Attending 124 hourserler death. • Funeral Director: Afti 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and manner stefed. edical 29a. Certifier (Check only one) 29b. Signature and fitte of contilio 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

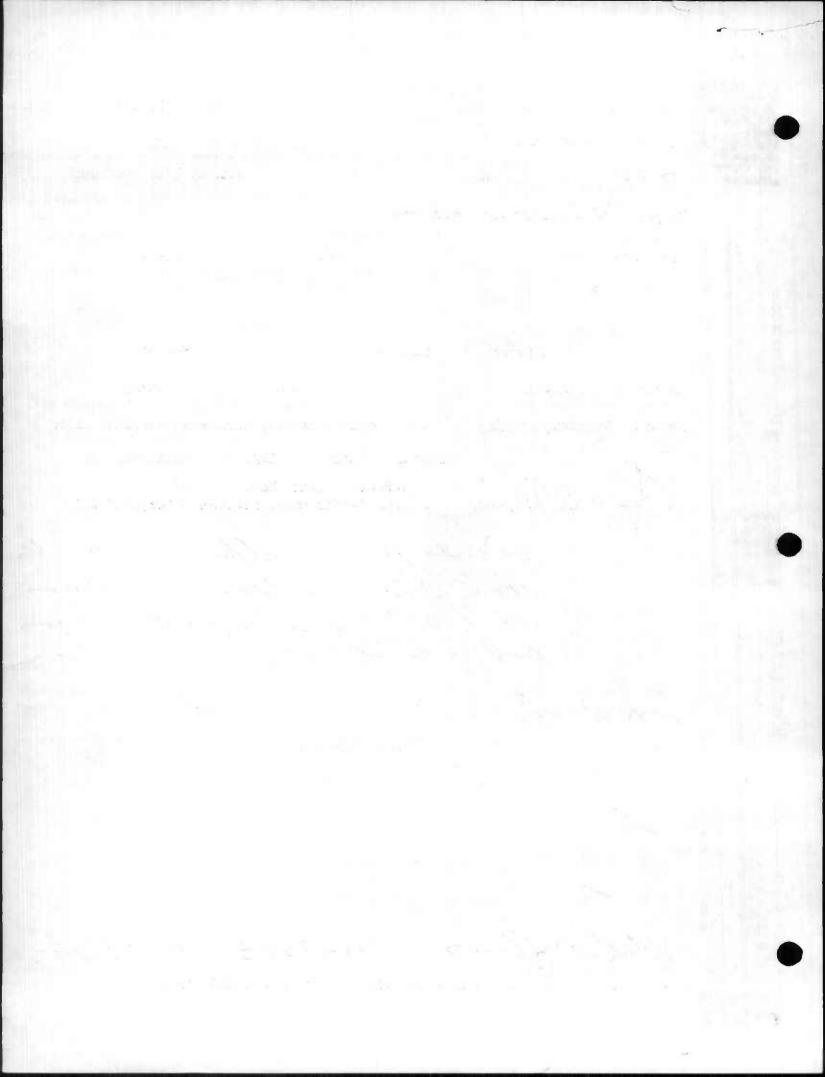
31. Date filed (Month, Day, Year) NOV 2 5 1997

Michael Hyle, M.D.,

30. Name and address of person who

6530 Walther Avenue, Baltimore, Maryland 21206 932. Registrar's Signature

ted cause of death (item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth 4e. Fecility Neme (If not institution, give street end number) NOV. 1400 4c. County of Deeth 4b. City, Town, or Location of Deeth 5. Social Security Number 6. Sex. 1246 - 22 - 73.33 MEDICAL ANNAPOLIS Co 8. Dete of Birth (Month, Dey, Year) DEC. 21, 1923 BLACKBURE, VA 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 226-22-7333 Months Deys Usuel Residenca of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2□ No AUNAPOLIS 10e. Street end Number 10g. Citizen of Whet Country? 21410 0.5 12. Wes Decadent Ever in U,S. Armed Forces? 1 Decade 2 □ No Bell St. Give Yeer or Detes: 14. Reca - American Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Merried 2 Married 1□ Yes 20 No Specify: 3 D Widowed 4 Divorced BLAC 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) JOHN SR. EDWARDS WILLIE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JOHN EDWARDS KINGS PORT, TN. 37660 Date 20c. Location - City or Town, Stete .O. BOX 20a. Nethod of Disposition 1 Burlei 2 □ Cremetion 3 □ Removal from State □ Donetion 5 □ Other (Specify) 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) HOMENAT. CEM. MOUNTAINHOME, TN 22. Name end Address of Fecility 21. Signature of Fangral Service Licensee 21224 BACT, MORE, 23a. Pert1. Enter the disease, complications thet caused the death. Do not enter the mode of dying, such as cardiac or respireton shock, or heart failure. Let only one ceuse on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3 Probably Duknown 1 ☐ Yss 2 ☐ No 24b. Were eutopsy findings avelleble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 1 ☐ Yea 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

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10e. Stete

Funeral

Director

show

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

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"natural",

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

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permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai

Baltimore, Maryland 21215-0020

Box 68760. The law requires that the death certificate be ax the use as P.O. I Records, page 2 Division of Vital or Attending Physician:

Examiner Physician/Medical Completed Be 20 in by the

this After death. To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:

Certification: Medical

State

completaly

31. Dete filed (Month, Dey, Yeer) 2 5 1997 Registrar

1 Yes

27. Manner of Death

2 Accident

3 ☐ Sulcide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

5 Pending investigation

6 Could not be

1 ☐ Inpatient 2 DER/Outpetlent 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Dete of Injury (Month, Day Year)

29c. License number

28c. Injury et Work?

1 Yes

150 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner stated. 29d. Dete signed (Month, Dey, Year)

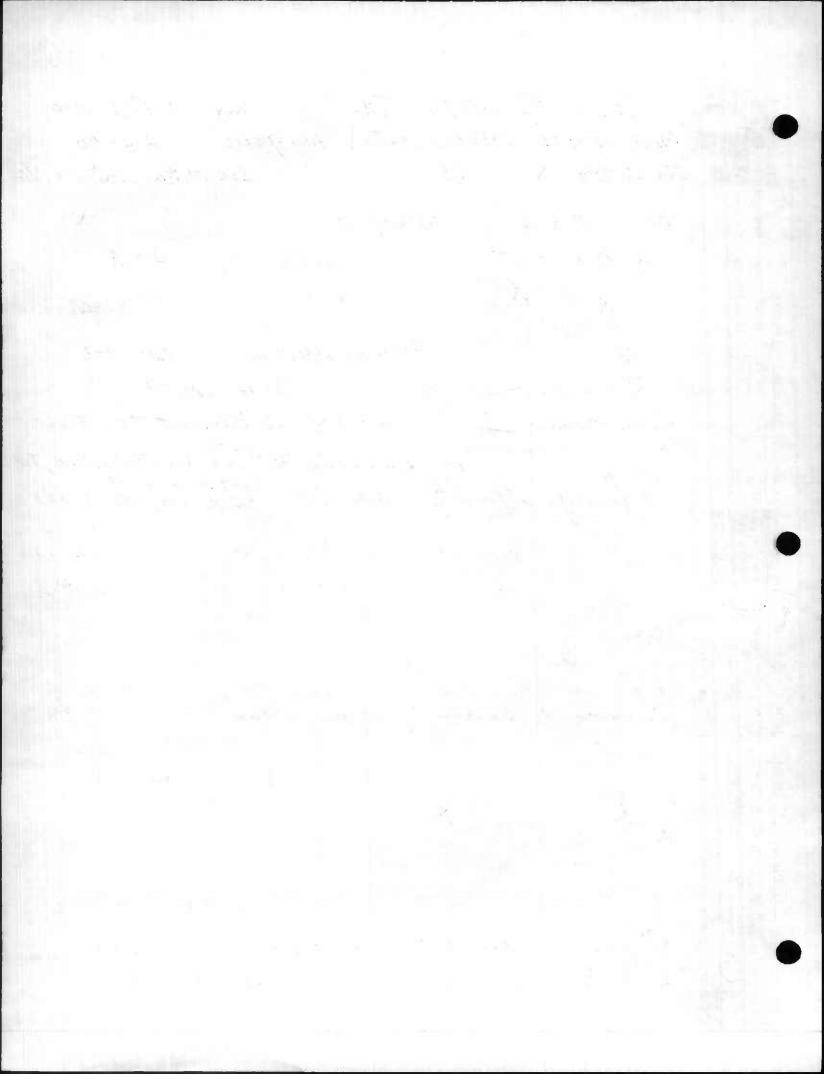
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Other: 4 Nursing Home 5 Residenca 8 Other (Specify)

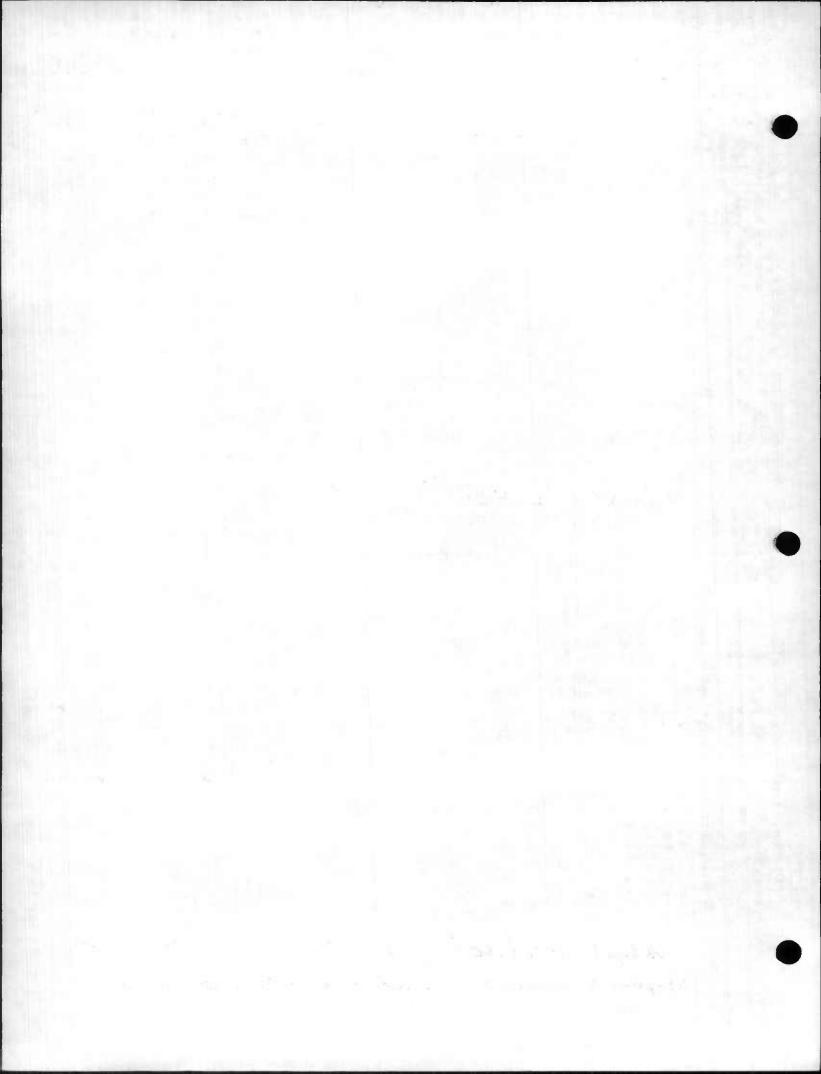
28d. Describe how injury occurred

2 🗆 No

James Ross 2003 Medical 32 Registrer's Signature

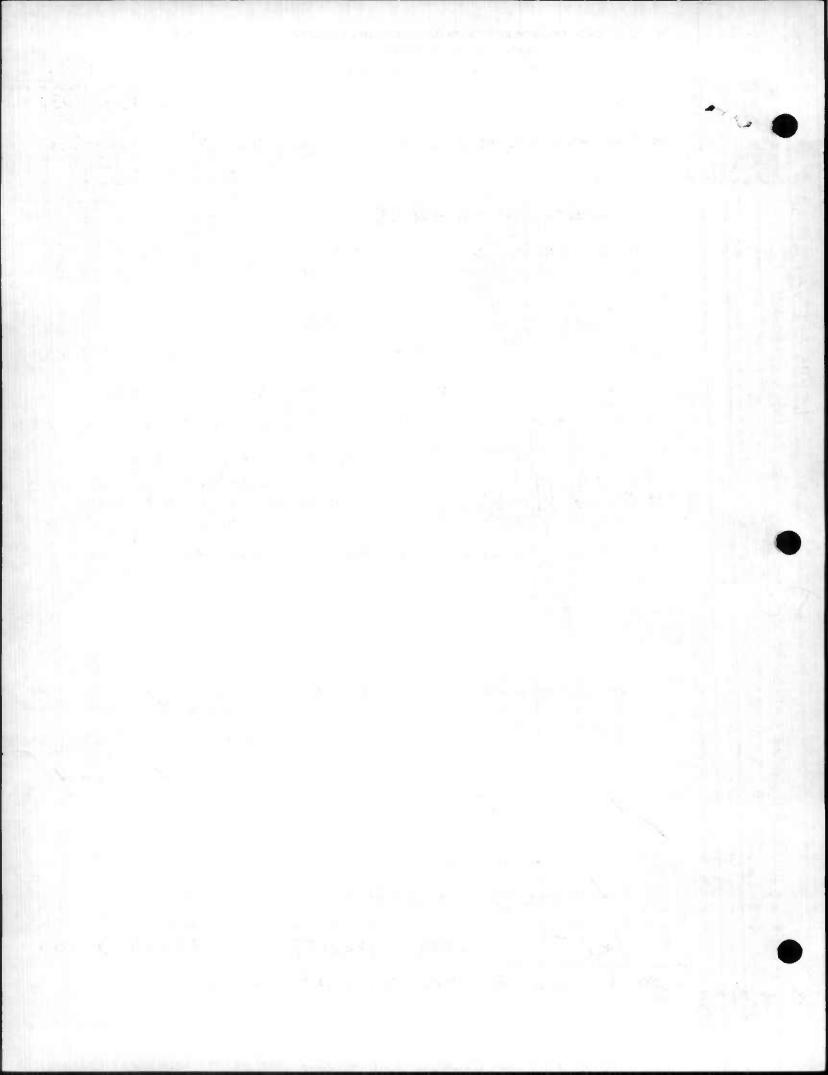


Element 1		rt I II 27 per MEO G-7 1. Decedent's Neme (First, Middle, La.			179	ertificate	e or	Dealli		2. Date of Dea			3. Time o	of Death
Physici /Medic		EARL	NORMAN	EI	OWAR	DS				Month NOV.	Day 19	Year 97	1230	0 PM
Examin	er	4a. Facility Name (If not institution, giv WASHINGTON COUL	11111	AL				HAGEF	RSTOV	cation of Deeth	4c. County	of Death INGTON		
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should be filed and Mental Hygis marked other imatic event, to	To Be C	17. Father's Name (First, Middla, Last) EARL NORMAN		s s	R.				r's Name VELY	(First, Middle,	Maiden Suman NARDS)		GH	
C1 0 20 E		19e. Informant's Neme/Retationship (7 EVELYN HAWF	Type, Print) KINS-moth	er	19b. Mail 4	Ing Address	(Street HBU	and Numbe	or or Rura	RT, RA	r, City or Town	State, Zin C	ode) MD	211
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£ 2 =		27. Menner of Deeth 1XX Natural 2 Accident 5 Pending Investigation	28a. Date of Injury (Month, Dey	A 54 X	b. Time o		Bc. Injun Wor		2	ne 5 Resid				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ma 23	Funeral	11. Marital Status							Specify Yas or No	USA 14 Re	ce - Amaricar	n Indian
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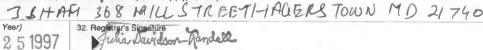
Registrar

31. Dete filed (Month, Dev. Yeer) NOV 2 5 1997

30. Name and address of person who completed causa of death (Item 23e) (Type, Print)

29b. Signature end title of certifier

MANZAL



29c. License number

29d. Date signed (Month, Day, Year)

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THE PRINCIPLE

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 7

		1. Decedent's Name (First,	Middla, La	st)			rtificate of		2. Date of Dea			3. Time	of Deeth
Physicia		Helen Agath	a Fol	derauer				N	OVEMBEI	Day R 22 1	Year 997	7:30	MA IS
/Medic Examin		4e. Facility Name (If not ins	titution, giv	a street and num	nber)			4b. City, Town, or L	-	4c. County			
	J	Saint Jos	eph t	Medica!	l Cen	ter		Towso		_	alti	more	9
Funeral Director		5. Sociel Security Number 212–10–2563		Sex I□M 2점F	7. Aga <i>(In yi</i> 80	s. lest birthday) Yrs.	If Under 1 Year Months Deys		8. Date of Birth (Month, Day Feb. 06	1917	9. Birthpl Count Mary 1	aca (Stati iny) and	ta or Foraig
how		Usual Residence of Deceder 10a. State 10b. C			10c. (City, Town or Lo	ocation				10		City Limit
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2 2	Dire	10e. Street end Number					10f. Zip Code		1	Og. Citizen of	What Count	try?	
23	rai	7001 North C	harle				21204			USA			
Department of Heelth and Mantal hygiene. Important: If Hem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be nothed at once.	by Funeral Director	11. Maritai Status 1 ☐ Nevar Marriad 2€ 3 ☐ Widowed 4 ☐ Div		12. Was Dece Armed For 1 Tas If Yes, Give Year or Da	ces? 21 No		Was Decedant of I If Yes, specify Cub 1 ☐ Yes 2\(\hat{2}\) No	Hispanic Origin? (Spean, Mexican, Puarto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e y: Wh		
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Men	10	Adam Klimcz						Mary Dz					
ls m		19a. Informent's Name/Rel	etionship (Type, Print)		19b. Meilin	ng Address (Street	t and Number or Rui	re/ Routa Number	r, City or Town	, Stata, Zip	Code)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month William J.tord November 22, 1997 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS AT MERCY BALTIMORE na 6. Sex. № M 2□ F If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funerai** Months Deys Hours \$15-18-3428 Vrs. Director JAN.1, 1922 MARYLAND Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 Xes 2 No MD BALTIMORE na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Herna 23a 3336 DOLFIELD 21215 AVENUE UNITED STATES should be filed within 72 hours efter death nd Mental Hygiene. marked other than "natural", or itema 23 Funeral 12. Was Decedent Ever in U,S. Armed Forces? XIV Yes 2 □ No If Yes, Give Year or Dates: 11 Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 8☐No Specify: by Specify. 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 th ARMED SERVICES NAVY UNITED STATES 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be nent of Haalth end Mental SAMUEL FORD HELEN THOMAS 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 s
Department of Haalth er
Important: if item 27 ia
any injury or other trau THERESA FORD 3336 DOLFIELD AVENUE, BALTIMORE, MD#15 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Berial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PARK 11-28-97 ARBUTUSMD 21. Signature of Fundal Service Licensee 22. Name end Address of Facility MARCH FH.-43000WABASH AVENUE Part 1. Enfer the disease, or complications that or used the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on parch line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Diagnosed 2/97) disease or condition resulting in death) MONTHS Examiner Due to (or es e consequence of) Examiner sician end buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or es e consequence of) Box 68760, ettending physician Physician/Medicai the Due to (or as a consequence of): P.O. | ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No signed b Records, þ pege 2 should 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 0 No certificate 1 ☐ Yes 2 ☐ No Division of Vital P Hospital or Attending Physician: 24 hodgs after beath.
Funeral Director: After this certifical etcly tube in by the funeral director; I Be 25. Was case referred to medical 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 650ther (Specify) Hospice 1 Yes 25€No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Alatural 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as steled.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

.2300 DULANEY VALLEY RD.

Wazu Regiorila de Bignativre

29c. License number

29d. Date signed (Month, Dev. Year)

November 22.

TIMONIUM, MD 21093

State Registrar 29a. Certifier

(Check only one)

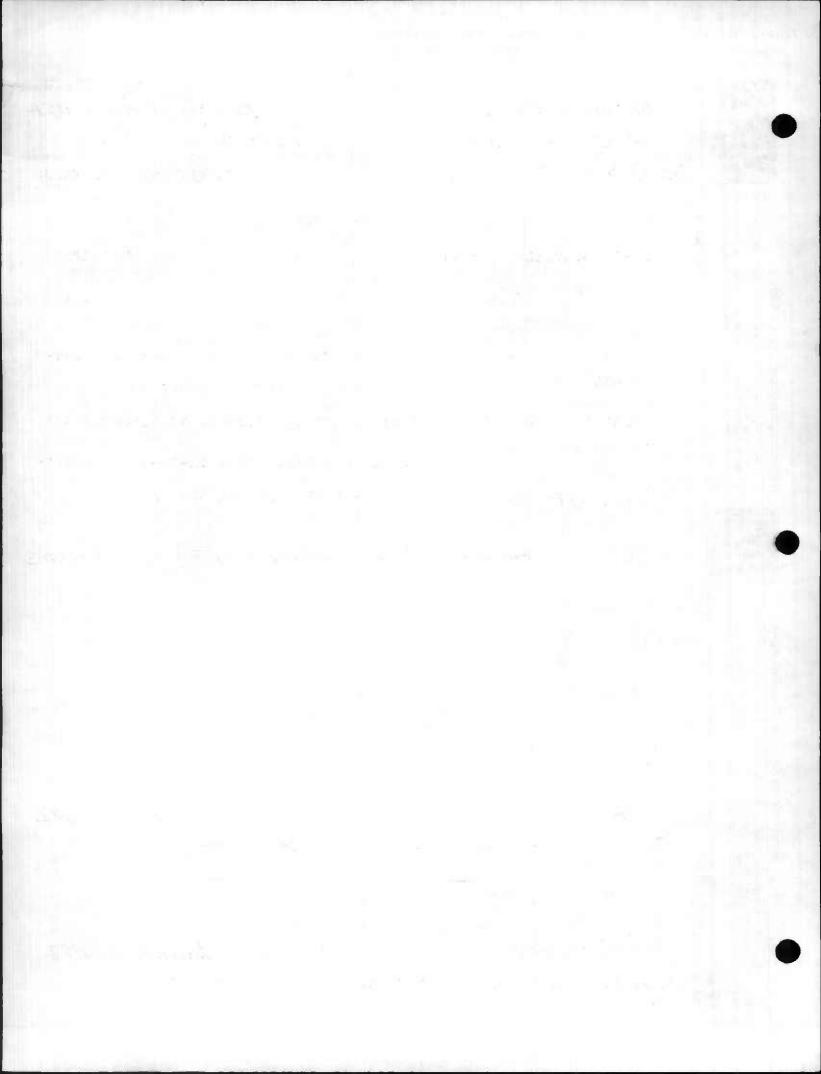
29b. Signature and title of certifier

PENELOPE EDWARDS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death HENRY Month FLAGGS. DAGE 2:10 AM 1997 NOVEMBER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTH NEST HOSPITAL BALTIMORE OLD COURT ROAD Baltimore If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1型 M 2□ F Days Hours Yrs. 75 213-14-8390 Feb 21, 1922 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 250 No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8612 Church Lane 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No 1942— It Yes, Give Yeer or Dates: 1946 1 Never Married 25 Married 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed). Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Klnd of Business/Industry Springfield Hospital Eiementery/Secondery (0-12) College (1-4or 5+) State of Maryland 10 years Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Flaggs Bernice Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Pnint) (Wife) 8612 Church Lane Randallstown, MD 21133 Mary Louise Flaggs 20e. Method of Disposition 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 11-24 Sykesville, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 Enter the disease, or complications that caused the or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximete Interval Between Onset and Death Immediate Cause (Final PINEUMONIA disease or condition resulting in death) Due to (or es e consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown YMPHOMA. 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 27. Manner of Deeth Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 Accident

The law requires that the death certificete be exe 68760, the USB as Box (Po P.O. á Records, is certificate has been signe director, page 2 should be certificate of Vital this

Examiner Physician/Medical by Completed Be 2 Certification:

Physician

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Baltimore, Maryland

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State Registrar

Medical

🗠 certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29b. Signature and title of certifier House PHYSICIAN 29c. License number 29d. Date algned (Month, Day, Year) ana/

D 42723

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NOVEMBER 1997

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who completed cause of death (item 23e) (Type, Print) ROAD STREAM 3745 FOXFORD HARISH AVVERAHALLI M. mp 21236. BALTIMORE

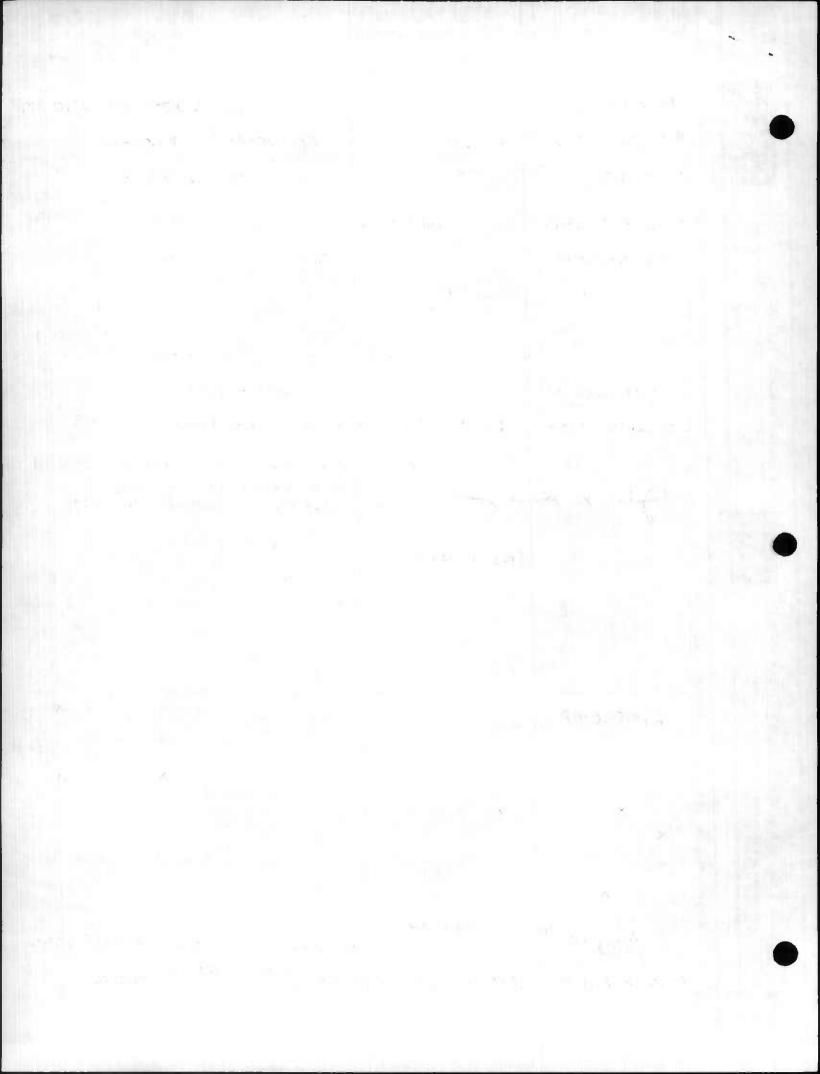
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6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Name (First, Middle, Last) 2. Dete of Deeth November Da17 Jabari J French 5.49 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 7. Aga (In yrs. last birthdey) It Undar 1 Yeer If Undar 24 Hrs. 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Days Mary and Yrs. Usual Rasidance of Decedant 10a Stete 10b. County 10c. City. Town or Location 10d. inside City Limits Maryland Baltimore Baltimore 1 Yas 2 □ No 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 2510 West North Avenue 21216 USA Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 Ø No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 18b. Kind of Businass/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) N/A N/A 17. Fathar'a Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Melden Surneme) Unknown Delisa French 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greater Baltimore Medical Center 6701 North Charles Street, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Other (Specify) 11 - 20Green Mount Crematory 1997 Baltimote, MD 22. Name end Addrass of Facility 21. Slametons of Funaral Sarvice Licenses Henry W. Jenkins & Sons 6 23a Pant Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a provided the disease of the di Approximata Intarval Between Onset and Death Immediate Carsa (Final disaase of cor dition rasulting In # ath) Extreme prematurity at birth 1-2 hours Dua to (or as a consequence of): Fully dilated maternal cervix with bulging membranes hours Saquantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of): Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No 26. Placa of Death (Check only one)

Physician /Medical Examiner

Physician

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Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

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25. Was casa ratarred to medical 1 Yes 2 No 27. Magpar of Death

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28a. Place of Injury - At homa, tarm, streat, factory, offica building, atc. (Specify)

28c. injury at Work? 1 ☐ Yas 2 No

Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Dascribe how Injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signeture and titia of common

29a. Certifiar

(Check only one)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)
Beth R. Schwartz, M.D. GBMC 6701 North Charles Street, Baltimore, MD

29c. License number D38352 29d. Date signed (Month, Day, Year)

11/19/97

State Registrar

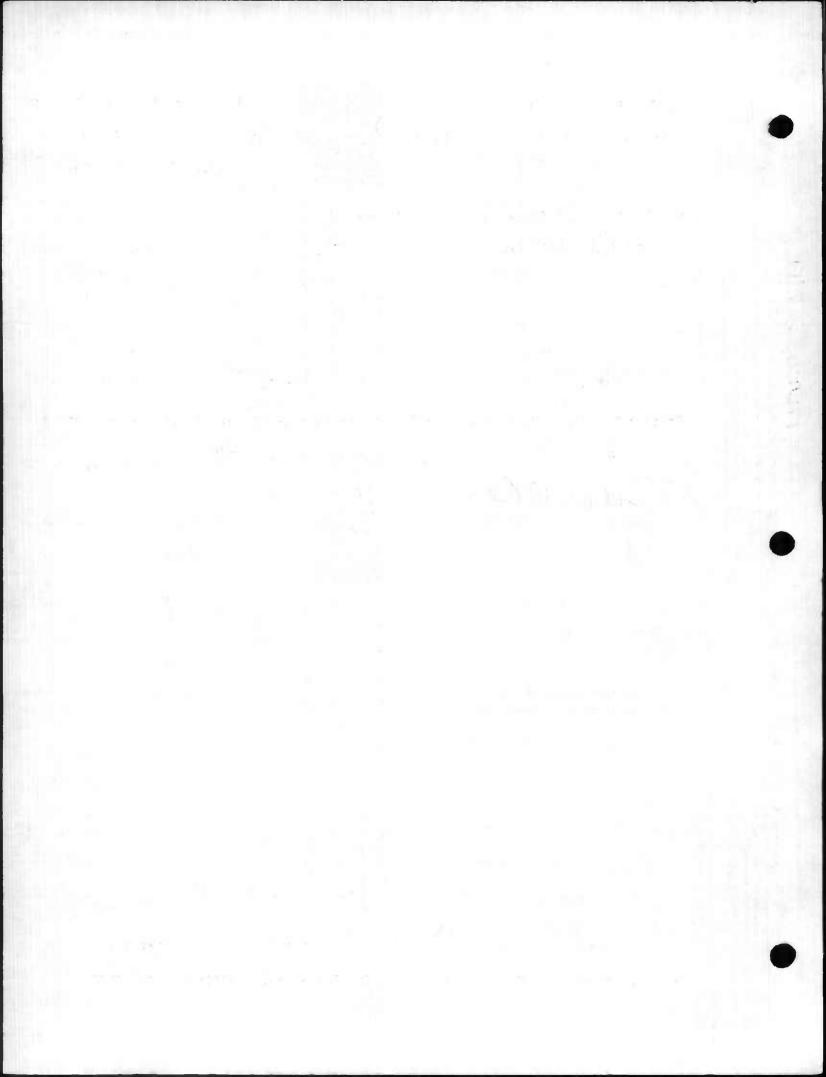
31. Dete filed (Month, Day, Year)

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To the Hospital o within 24 hours aff To the Funeral DI completely filled in



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** tilkles 10 /Medical 1540 4e. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner (ひつん) 1405.6 C1 521 1-10. If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours 53 November 10, 1997 5. Social Security Number 6 Sax 7. Aga (In yrs. lest birthday) 9. Birthpiece (State or Foreign **Funeral** 1 M 2 F Months Mary land n/a Yrs. Director Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at Maryland Howard County Columbia Funeral Director 1 ☐ Yes ZZINo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5308 Cedar Lane; Apt. 217 21044 USA 12. Was Dacadant Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No if Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bieck, White, atc. 11. Maritei Status filed within 72 hours efter ☐ Yes 2 ☐ No f Yas, Give Navar Merried 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes ZENo Specify: African-Completed by 3 Widowed 4 Divorced Yaer or Dates: American 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highast grede completed) I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) n/a n/a permit. Pages 1 end 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William Henry Scott Cynthia Felecia Finkley 19e. informant's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. William H. Scott/father 5308 Cedar Lane; Apt. 217, Columbia, MD 21044 20e. Method of Disposition 20b. Piece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete DaBurial 2 □ Cramation 3 □ Removal from State Columbia Memorial Park 14NOV97 Clarksville, MD 4 Donation 5 □ Other (Specify) Signeture of Funeral Service Licensee 22. Name end Address of Fecility Slack Funeral Home, P.A. 23a. Pert1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilura. List only one cause on each line. Approximete intervel Between Orbet and et and Deeth Physician /Medical Immediete Cause (Finel isaese or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest P.O. Box 68760 physician Attending Physician: The law requires that the death certificate but cian/Medical the Due to (or as e consequance of): **USB 88** ettending I aigniticent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by the Phy 1 Yes 2 76 3 Probably 4 Unknown Division of Vital Records, þ Completed 24b. Were autopsy findings evailable prior to 24e. Wes en eutopsy performed? completion of cause of death? certificate hes 1 Yes 2[No Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 27. Menner of Deeth Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After 5 Pending investigation To the Hospital or Attendin within 24 hours efter deeth. To the Funeral Director: Aff completely filled in by the fu 1 Yes 6 Could not be determined 3 Suicide Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 I Homicide Certifying Physician: To the talks of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical prominer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner plated. Medical 29a. Certifier (Check only

State Registrar

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31. Date filed (Month, Dey, Year)

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32. Registrer's Slonature ina Davidson

is of person who completed cause of deeth (Item 23e) (Type, Print)

29c. Licansa number

11055 Little Paturent PKwy. Suite 103 Columbia, mo 21044

29d. Data signed (Month, Dey, Year) 11/10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 3 5 5 4 8 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** WILLIAM GREENE LACV NOVEMBER 19, 1991 /Medicai 4e. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death GIETV BULLVIE

er If Under 24 Hrs. 8. Date of Birl
ys Hours Min. (Month B Examiner NORTH ARUNDEL AA COUNT HOSPITAL If Under 1 Yeer Months Days 8. Date of Birth (Month, Day, Year) 9. Birthpiece (State or Foreign Country)

APRIL 13, 1918 PENNSLYVAN I A 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F 79 219-01-1635 Yrs. Director Usual Residence of Decedent the Marylend permit. Pages 1 end 2 should be filed within 72 hours effer death with the Marylen Depertment of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or fiems 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No A. A. COUNTY Directo MARYLAND SEVERNA 10e. Street and Number 10g. Citizen of What Country? 309 RITCHIE HIGHWAY USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Xyes 2 No 9 - 8 - 41
If Yes, Give
Year or Dates: 01 - 24-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 +HGRADE ONDUCTOR BETHLEHEN STEEL 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM L. GREENE TUCKER 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) GERTRUDE M. GREENE (WIFE) 309 RITCHIE HIGHWAY, SEVERNA PARK, MD, 21146
laca of Disposition (Name of Date 20c. Location - City or Town, State Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State MARYLAND NATL CEMETERY 11-24-97 LAUREL, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Servica Licans 22. Name end Address of Facility BROWN JR. FUNERAL HOME, P.A. JOSEPH H. BROWNJ 2140 N. FULTON AVE. Sharran BALTIHORE, MD. 2/2/7

Approximate
Interval Between
Onset and Death 234. Pert1. Enter the disease, or complications that control the death. Do not enter the mode of dying, such as cardiac or respiratory ages shock, or heart failure. List only one cause on such line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SEPSIS Examiner HRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of): buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last MESTIVE HEART physiclan the death certificate be Physician/Medical es the EIZURE ettending p DISORDER Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yss 2 No 3 Probably 4 Unknown à should should 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy periormed? 1 Yes 2 No After this certificate 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of fnjury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 T Homicide Hospital c To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) For Dr. Onchijo

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19, 1997

State Registrar On clayo

31. Date filed (Mohth, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrat's Signature

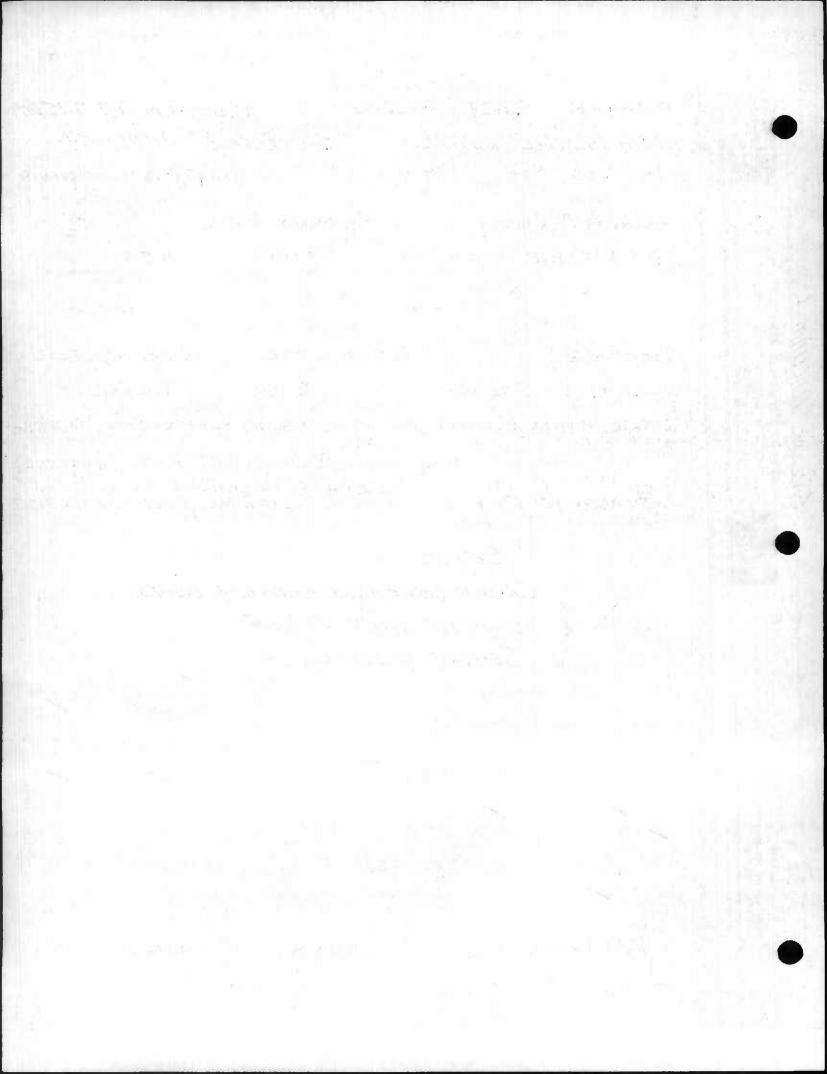
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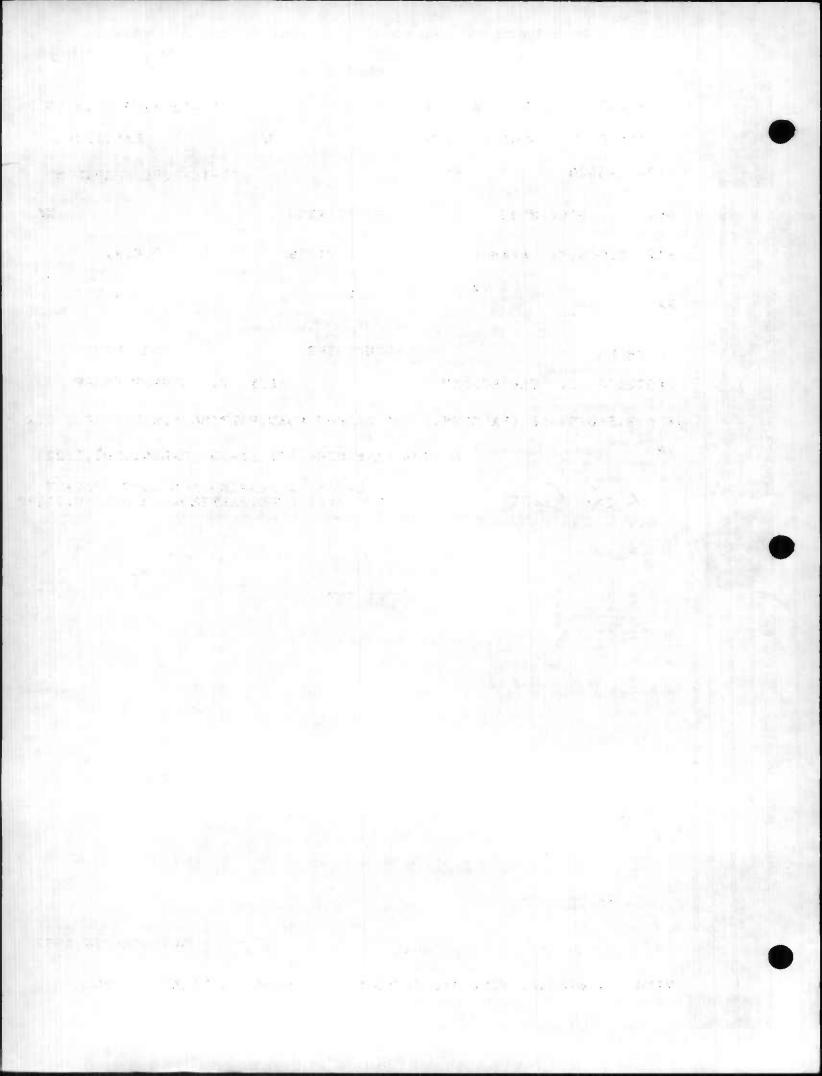
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State of Maryland / Department of Health and Mental Hygiene 7 3551, 9

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by Funeral Director	11. Marital Status 1 Never Married 2		12. Was Decedar Armed Force 1 Yes XI If Yes, Give Yeer or Detes	s? ¶No		cedent of pecify Cul	Hispanic Origin? (Speed, Mexican, Puerto Specify:	pecify Yas or No Ricen, etc.)		ce - Americ ck, White, y: WH]	
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page 2 should										of	omplation of causa death?
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completely filled in by	29a. Certifier (Check only one) Certifier 2 Med	Ifying Phy Ical Exami	sician: To the besiner: On the basis end menner	st of my knowledge of examination a	ge, death occur and/or investigat	ed at the tion, in my	time, date and place opinion, deeth occu	, and due to the rred et the time,	cause(s) and m date and place,	anner es s and due t	stated. to the cause(s)
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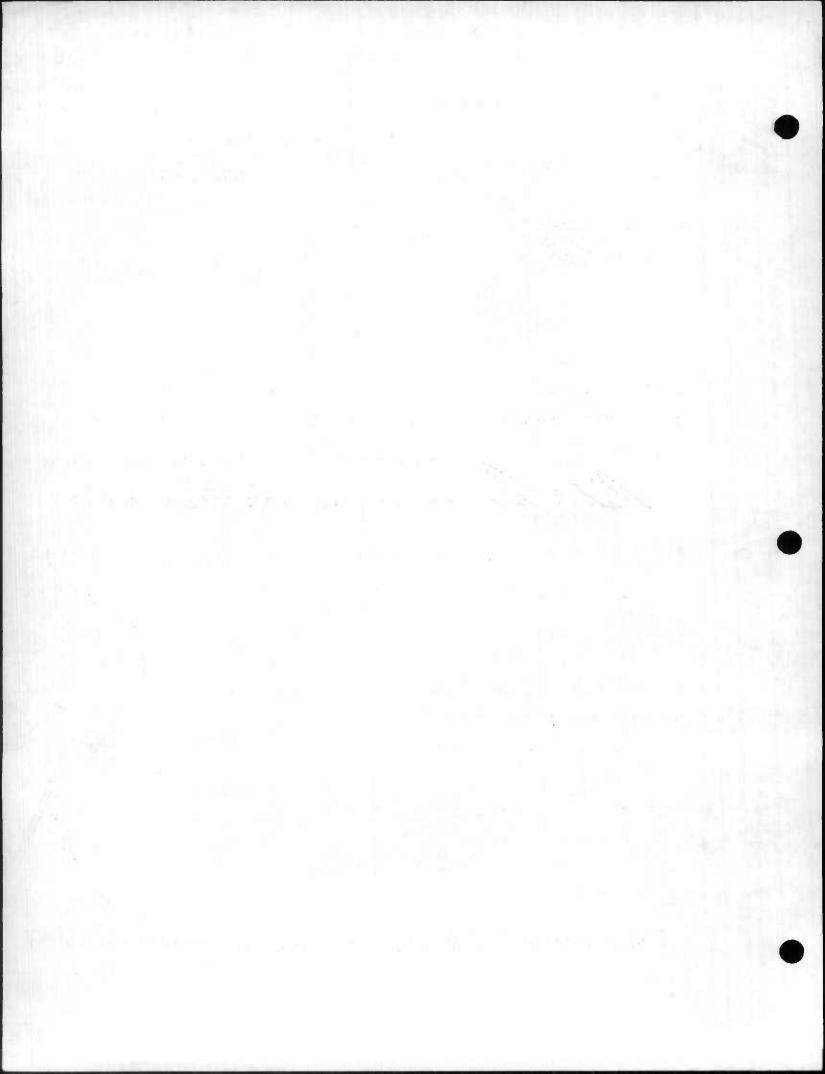
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month **Physician** GEORGE GREEN 8:10 AM NOVEMBER 23 97 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CENTER NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE if Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5 Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** X M 2□F Months Yrs. Director 213-10-4899 84 JAN. 5, 1913 MARYLAND Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yes MNo Directo MARYLAND BALTIMORE REISTERSTOWN 10e. Street and Number CHERRYWOOD NURSING HOME 10g. Citizen of Whet Country? 8 23a 12020 REISTERSTOWN ROAD 21136 U.S.A. death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Raca - American Indian Biack, White, etc. the Medical Examiner 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE À 3 Widowed 4 □ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuai Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 DISPATCHER FUEL ant of Haalth end Mental Hy t: If Item 27 Is marked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be GEORGE F. GREEN SR. MARY ELIZABETH MILES 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LINDA LANGLOIS, DAUGHTER 7226 MORGAN ROAD, WOODBINE, MARYLAND 21797 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriat 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or LOUDON PARK CEMETERY 11/26/97 BALTIMORE, MARYLAND 21. Signature of Fungal Survice Licensee 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final & H-IPEROSMOLAR disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner DIABETES MELLITUS Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): be ax Box 68760 Physician/Medical the Due to (or es e consequence of) P.O. Part If. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 2 Onknown CORONARY ARTERY OISEASE Records, Completed 24a. Was en eutopsy performed? 24b. Were eutopsy findings aveileble prior to MULTIPLE CEREBRO VASCILAR ACCIDENTS completion of cause of death? The 1 Yes 2 No certificata 1 ☐ Yes 2 ☐ No Division of Vital tal or Attending Physician: Tre ofter deeth.

al Director: After this certificated in by the funeral director, pa Be 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours of
To the Funeral DI
Completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) end manner es stated.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) K.S.RAO.MI.D. NOVERBER 23 D43462 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MORTHWEST HOSPITAL CENTER RANDALLSTOWN T10 32. Registrer's Signeture 31. Date filed (Month, Day, Year) NOV 2 5 1997

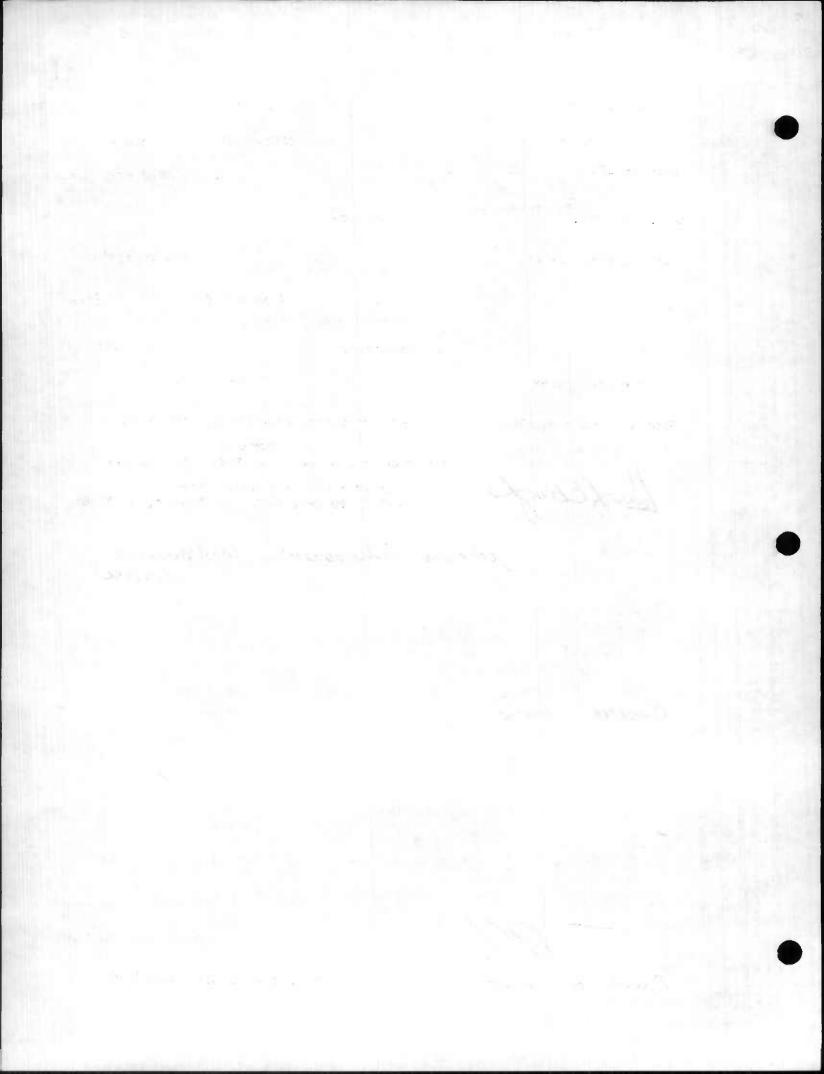
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State of Maryland / Department of Health and Mental Hygiene

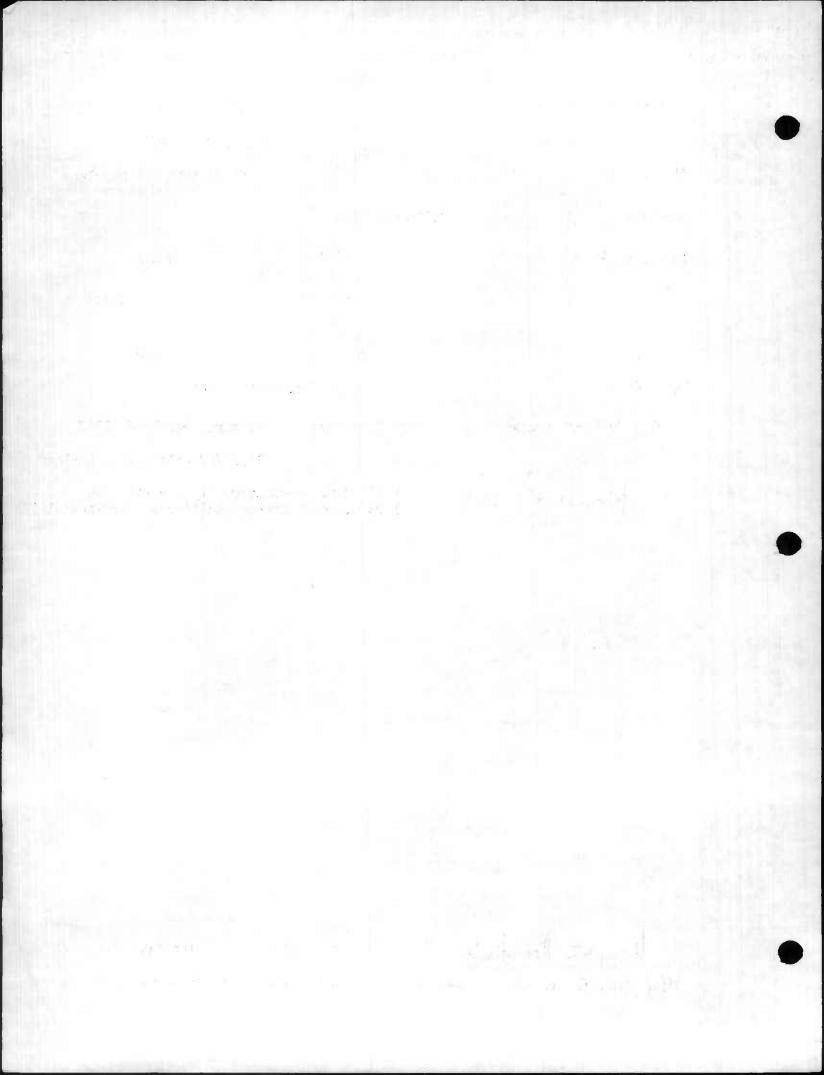
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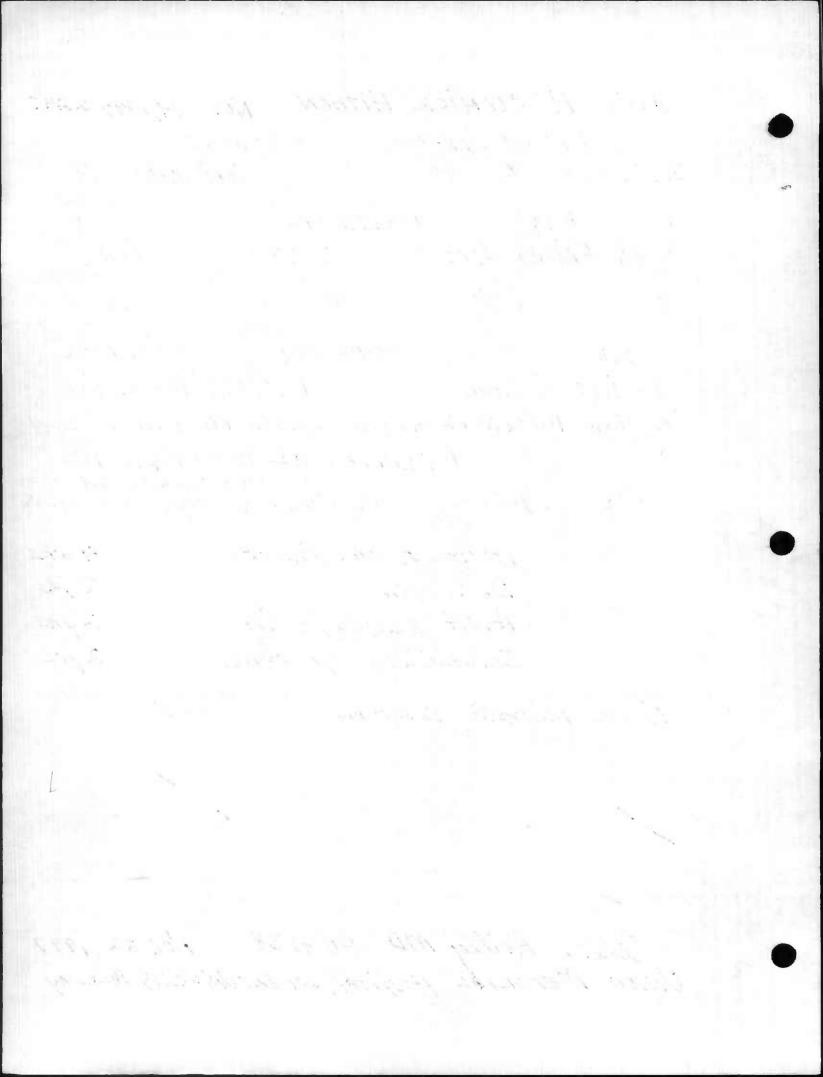
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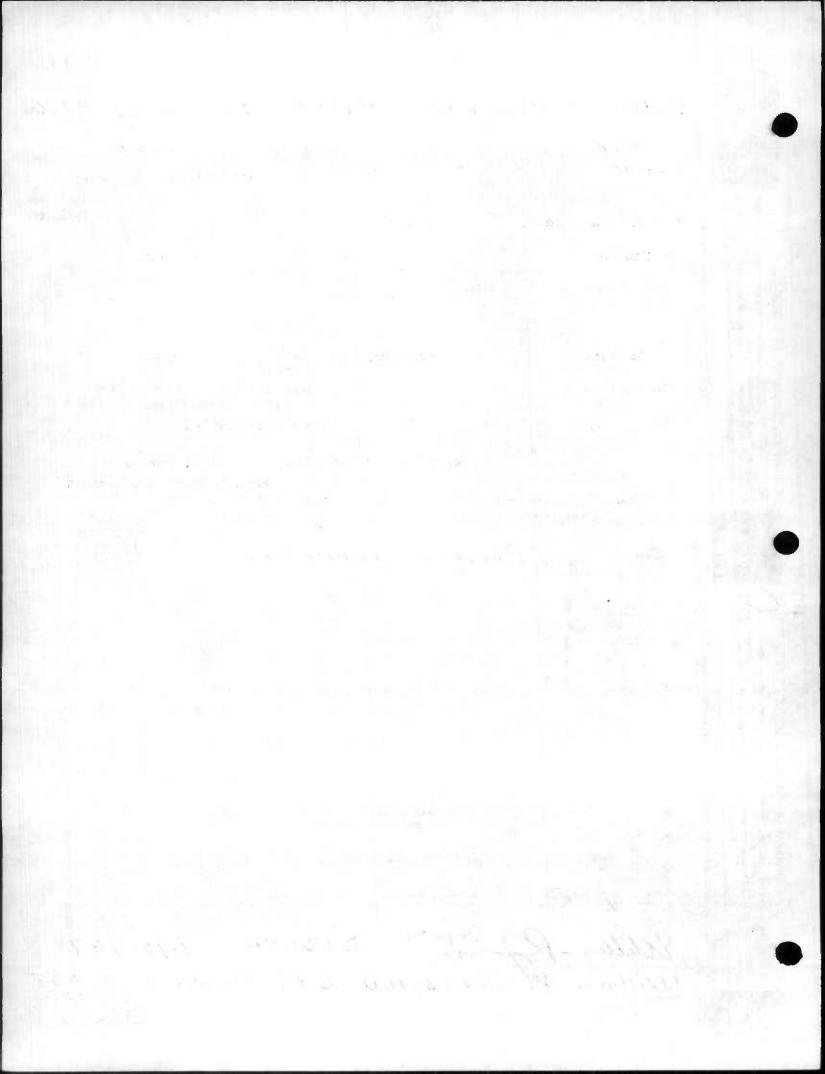
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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month 745 erman 13 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 0+ N/A Mary Hospital land If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 24 Hrs. Birthpleca (Stata or Foraign Country) Days Months Hours 212-16-3013 MD Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits ANNE ARUNDEL GLEN BURNIE 1 Yas 2 No 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of Whet Country? 105 LOUISE TERRACE 21060 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11, Marital Status 1 Navar Marriad 2X Married 1 XYas 2 No If Yas, Giva Yaar or Datas: 1 Yas 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elemantary/Secondary (0-12) SALESMAN TATE ENGINEERING 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) HERMAN A. HORZ, ELIZABETH UNKNOWN 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rurel Route Number, City or Town, Stata, Zip Coda) 105 LOUISE TERRACE, GLEN BURNIE, MD 21060 BETTY FLOYD - DAUGHTER 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramovai from Stata LOUDON PARK CEMETERY 11/17 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funaral Sarvice Licensaa 22. Name and Addrass of Facility
RAYMOND C. FINK FUNERAL HOME 426 CRAIN HWY., GLEN BURNIE, MD 21061 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Finai Sepsis

Dua to (or es e consequence of): disaasa or condition resulting in daath) 2 months co use contribute to the cause of death? 3 robebly 4 □ Unknown 24b. Wara autopsy findings aveilable prior to itopsy complation of causa of death? 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, Stata

MD

Funeral

Director

28a-f show

items 23a or

pemit. Pages 1 and 2 should be filed within 72 hours efter deeth 1 Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Expressions.

Baltimore, Maryland 21215-0020

Examiner must be notified at

Director

Funeral

by

Completed

Be

with the Maryland

Jer attanding physician and for use es the buriel-transit signed t page 2 should Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica filled in by the funeral director

The lew requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to Immadiata ceusa. Entar Underlying Causa (Diseese or Injury that intitleted events	Dua to (or es a consequance of):	70077011		
that initieted events resulting in death) Last	Dua to (d	or as e consequance of):			
Part II. Other significant conditions con My o card ra					ontribute to the cause of d
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25. Was case refarred to medical			26. Placa of Da	aath (Check only one)	
axaminar?	Hospital: 1 phopatient 2	ER/Outpatient 3 DOA		Homa 5 ☐ Rasidance 8 ☐ Oti	har (Specify)
27. Menner of Death 1 Death 1 Death 2 Accident 2 Accident	28a. Data of Injury (Month, Day Year)	28b. Time of Injury M	injury at Work? 1 ☐ Yas 2 ☐ No	28d. Dascribe how injury occu	rred
3 Suicida 6 Could not be datarmined	28a. Place of Injury - At h building, etc. (Speci	ome, ferm, straat, factory, of	office	28f. Location (Straet and Num City or Town, Stata)	ber or Rural Routa Number
29a. Cartifiar (Check only one) Certifying Physical Examination (Check only one)	alcian: To the best of my knoner: On the basis of axamina and mannar stated.	owledge, deeth occurred at ation and/or investigation, in	tha tima, deta end place my opinion, daath occ	e, and dua to the cause(s) and m curred at the tima, data end placa,	enner es stated. , and due to tha ceuse(s)
20h Signature and title of certifier		200 1	iaanaa numbar	and Data sleet	ad (Month Day Vans)

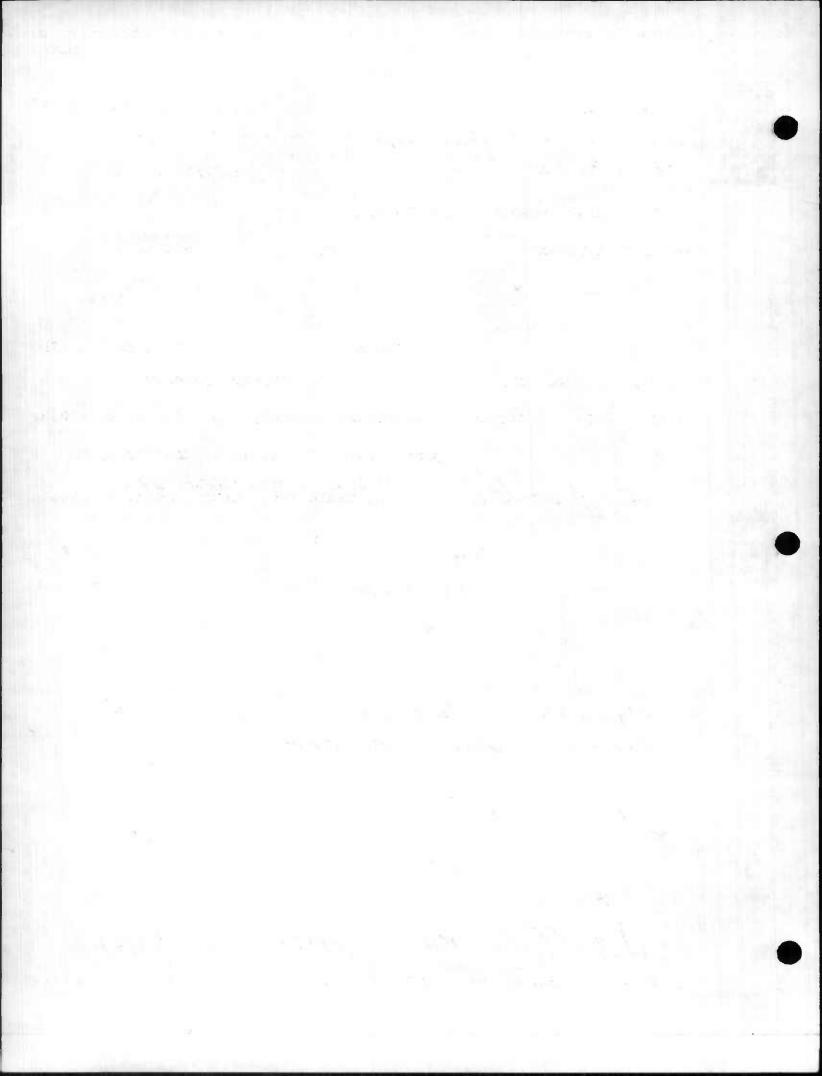
Technifying Phyalcian: To the best of my knowledge, deeth occurred at tha tima, deta end place, and dua to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data end placa, and due to tha ceuse(s) and mannar stated. 29a. Cartifiar (Check only one) 29c. Licansa number 29d. Data signed (Month, Dey, Year)

30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

C. DAVIS MD 22

State Registrar 31. Date filad (Month, Day, Yaar)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 12:4047 Rolandboltuyes /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Affairs Kaltimore Baltimore Baltimore Veterans Hospital If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplece (State of Foreign Country) 6 Sex **Funeral** 12M 2□ F Months Deys Ma 213-20-9463 0 Director res Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examinar must be notified at Baltinoce Md NA 1 Yes 2 No Director 10e. Street and Number 10f. ZIp Code 10g. Citizen of Whet Country? VIEGINIA AZU 3303 21215 Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No If Yes, Give Yeer or Detes: 11. Meritef Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examples. 1 Never Married 2 Merried 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 lac þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Batto Elementary/Secondary (0-12) College (1-4or 5+) Santation Dept. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HENRU Lockley SARAH HAYES 19e. Informent's Neme/Reietlonship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRIENCL 3303 Virginia Dalto Md 21215 ELEANDR 20b. Piece of Disposition (Name of cometery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Owinas Hills Garrison Forest Vet Con 28 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signature of Funerel Service Licenses larch 23e. Pert . Enter the crease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel from C. difficile Colitis a. Toxic megaculon tro

Due to (or es e consequence of): diseese or condition resulting in deeth) Examiner Examiner ICChemic Colitic ate has been signed by the attending physician end page 2 should be detached for use as the burial-trensit thet the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2) 1 Yes 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? this certificate has 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending investigetion 1 Naturel 2 Accident death. To the Hospital or Attendit within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end manner as stated.

Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted. 29a. Certifier

Records, P.O. Box 68760, Division of Vital

1+1 State Registrar

Medical

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Richard Wingkur 31. Dete filed (Month, Day, Year)

22. Registrar's Signature

29c. License number

29d. Dete signed (Month, Day, Year)

V.A. Hospital, Department of Surgery

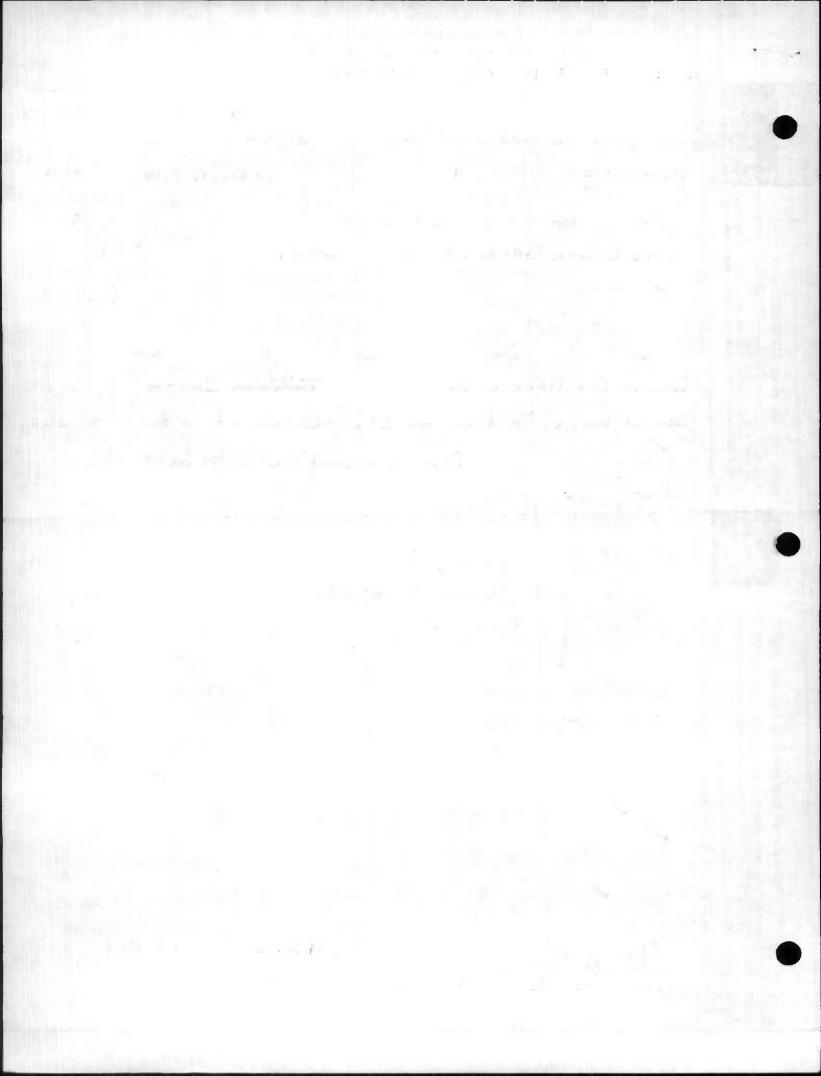
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29b. Signeture and title of certifier

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State of Maryland / Department of Health and Mental Hygiene

Physic	ian	Decedent's Neme (First, Middla, Las	David	Lee Hom	is Ir.	2. Deta of De Month	Dey	Year (6:35
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Funeral Director		5. Sociel Security Number 6. St 212-49-0176			der 1 Yeer If Undar 24 Hr	rs. 8. Data of Bir	th ay, Year)	9. Birthplece (State of Country)
26a-f show	or	Usuel Residence of Decedent 10a. Stete 10b. County M A N A		City, Town or Location Baltimo				10d. Inside City
3a or 26a-f	Funeral Director	10e. Street and Number 4442 CEDAR			Zip Code		10g. Citizen of V	1
al', or items 2 Examiner mu	by	11. Marital Status 1 Nevar Marriad 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forces? 1 Yes 2 No If Yes, Give Yaer or Dates:		cadent of Hispenic Origin? (pecify Cuben, Mexican, Pue	(Specify Yes or No erto Rican, atc.)	Specify	a - American Indien, ck, White, etc.
than "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementery/Secondery (0-12)	ucation de completed) Coilege (1-4or 5+)	life. DO NOT	work done during most of w	rorking	16b. Kind of Bu	usiness/Industry
marked other	To Be Co	17. Fether's Nama (First, Middla, Last)	ARRIE SE		-	ame (First, Middla		
ran trau		19e. Informent's Neme/Relationship (7	ype, Print)	19b. Meiling Addre	ess (Street end Number or F			
oth de		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removel from State	Place of Disposition (fi	lame of	Dete		City or Town, Stete
Important: If any injury or once.		21. Signature of Lumiral Service Licens			end Addrass of Facility	est	die su	10 Bally
ysician		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the de one ceuse on aech lina.	eth. Do not enter the m	ode of dylng, such es cardi	ec or respiretory e	rrest,	Approximate interval Betwoonset and Do
ledical aminer		Immediate Ceuse (Final disease or condition resulting in death)	Pocartan	1. 1				
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 8, per F.H. G-754 12/1/97 reb Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 1:14 PM John D. Hill 97 H 22 /Medical 4a. Facility Name (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cipy Johns Hofkin Bayveir 5. Social Security Number 6. Sax 7. Ag Medical Center Balkomore If Under 1 Yaar Months Days If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 6. Data of Birth 9/25/56 (Month, Dey, Year) Birthplaca (Steta or Foreign Country) **Funeral** Hours Min. 15 M 20 F Director 218-76-4814 41 MARYLAND Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director MD BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 7284 BRIDGEWOOD DRIVE USA Funeral 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give Year or Dates: Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: P WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry NATIONAL CREDIT Elementery/Secondery (0-12) College (1-4or 5+) 12th GRADE CLERK MANAGEMENT CORP. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumama) CLYDE S. HILL MARGARET E. COLL 0 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) WIFE JACKIE L. HILL 7284 BRIDGEWOOD DRIVE BALTIMORE, MD 21224 20b. Place of Disposition (Nema of cametery, cremetory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or once. 4 □ Donation 5 □ Other (Specify) 11/26/97 COCKEYSVILLE, MD DULANEY VALLEY MEM. GAR. 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. the 23a. Part. Enter the disease, or complications trial caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Physician /Medical Immediata Causa (Final disease or condition resulting In death) Cardiac Arrythmia Examine Examiner Sequantially list conditions, if any, laading to Immediata cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical Dua to (or as a consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown P 24b. Were autopsy lindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No 25. Was case refarred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 20 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 26a. Date of Injury (Month, Dey Year)

physician 9 88 880 à Division of Vital Records, P.O. 2 3 bengis 5685 has **Dege 2** certificate director, 튑 uneral Attending

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s or 28s-f show ary or other traumatic event, the Medical Examines must be notified as

Baltimore, Maryland 21215-0020

if or Attans after deatl Director:

To the Hospital
within 24 hours a
To the Funeral C
completely filled

State

Registrar

Certification:

Medical 29b. Signature and title of certifier Bosmann)

27. Menner of Death

1. Netural

2 Accident

3 ☐ Sulcide

29e. Certifier

4 Homicide

(Check only one)

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number DZ8684

🕊 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

28c. fnjury at Work?

1 ☐ Yes 2 ☐ No

29d. Data signed (Month, Day, Year) 11/22/97

281. Location (Street end Number or Rural Route Number, City or Town, Stata)

28d. Describe how injury occurred

Hopkins By view Nedical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward S. Bessman

5 Panding investigation

6 Could not be determined

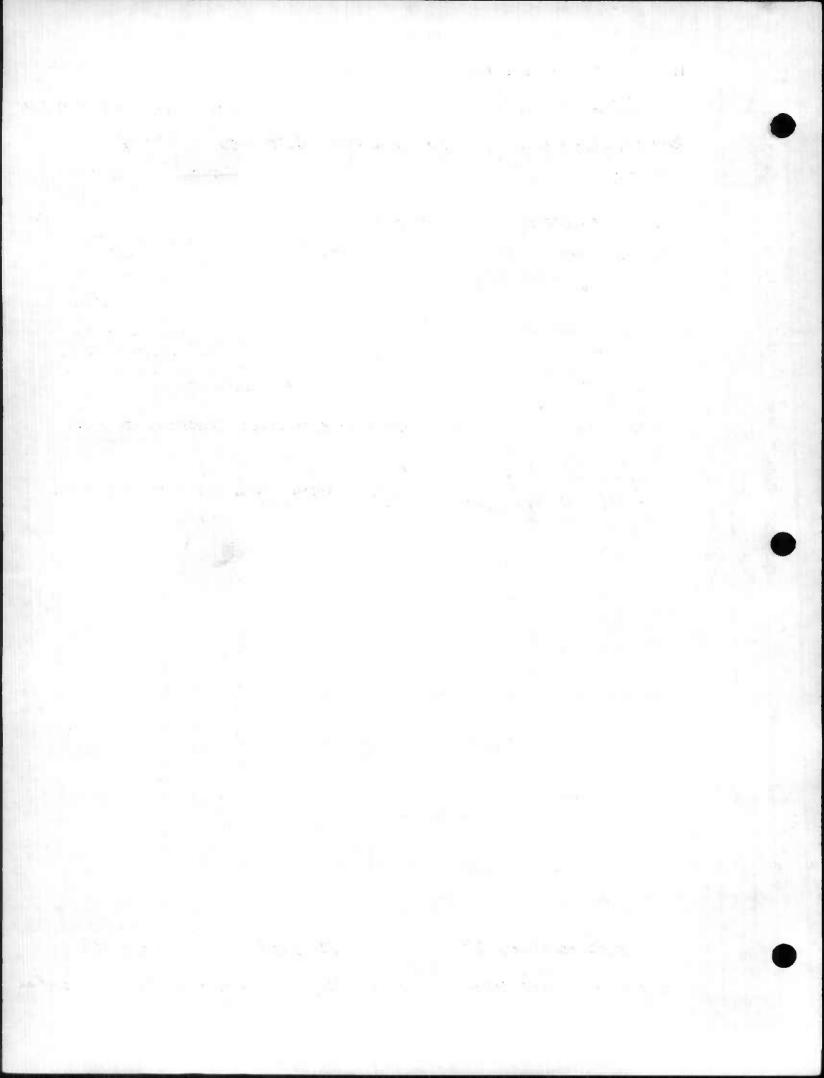
Johns

28h. Time of

26e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Dey, Year)

32. Registrar's Signature ia Varideor-Gandell



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Month Mary Hoffman NOV 23 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital a Lto. If Undar 24 Hrs. Bon Secours Md N/A If Undar 1 Yaar 7. Aga (In yrs. last birthday) 5. Social Sacurity Numbar 6. Sax 8. Data of Birth Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2XF Days Hours Yrs. Director 212-58-7790 11/29/1909 Maryland Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Maryland Baltimore Baltimore 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? ò 5307 Old Frederick Rd. 21229 238 USA death Funeral Hems ? 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black White atc filed within 72 hours after 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 6 Baltimore, Maryland 21215-0020 1 □ Yas 2 No by Specify: White 3√Widowed 4 □ Divorced "natural', Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacadant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Collega (1-4or 5+) 10th Housewife Domestic ... or reselth and Mental Hyg.
tt: if item 27 is marked. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Joseph Jarboe Frances Yinger 19a. tnformant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 5307 Old Frederick Rd. Baltimore, Maryland 21229 Mary C. Kafka / Daughter 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata permit. Peges 1
Department of H
Important: If ite
any injury or ott XSurial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Spacify) 11/26/97 Baltimore, Maryland New Cathedral Cemetery 21. Signature of Funaral Sautice License 22. Nama and Addrass of Facility David J. Weber Funeral Home 5311 Edmondson Ave. Baltimore, Maryland 21229 23a. Part1. Entar the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Baty Opent and F Physician /Medical Immediata Causa (Finai disaasa or condition rasulting in daath) Examiner and I-transit Saquantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that Initiated avants rasulting in death) Last ettending physician a for use as the burielcertificate be Physician/Medicai P.O. ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, by 24b. Wara autopsy findings available prior to completion of cause of death? pege 2 should Completed 24a. Was an autopsy performed? hes certificate 1 Yas 2 No 1 Yas 2 No Division of Vital Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) To Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Manner of Daath Data of Injury (Month, Day Year) Certification: 28b. Tima of 28d. Dascribe how injury occurred Injury at Work? After or Attending 5 Panding Invastigation Injury within 24 hours efter death.

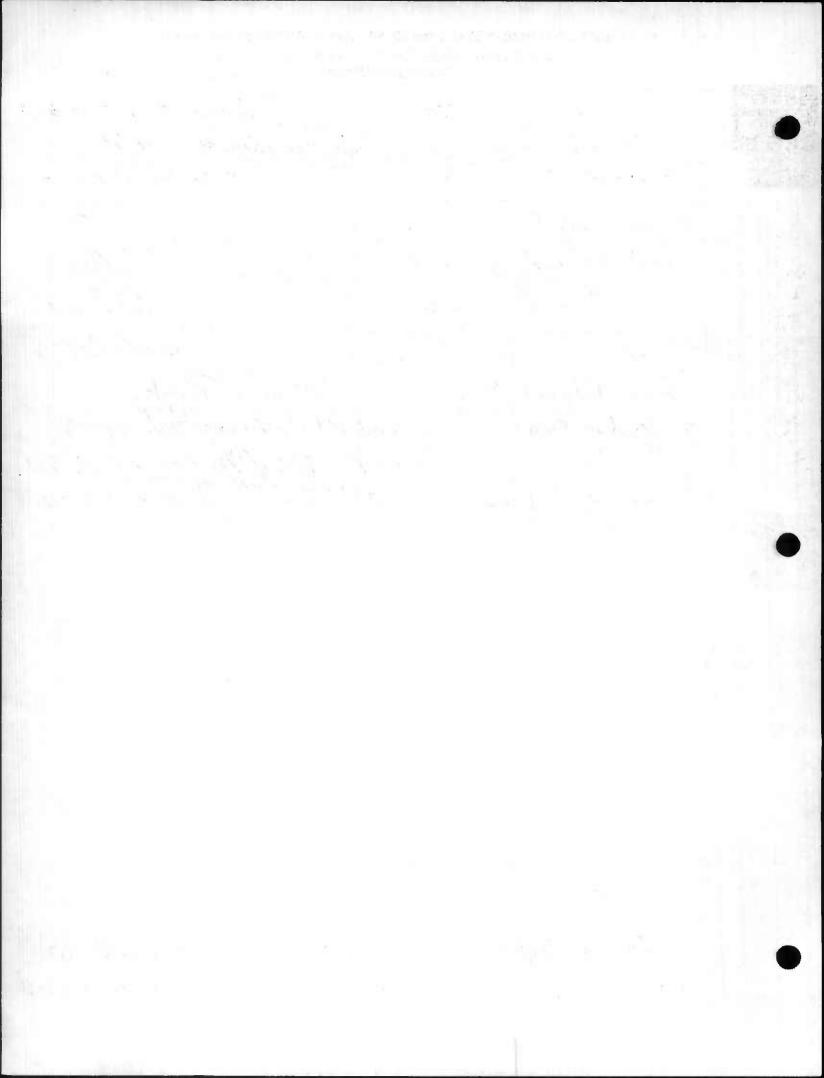
To the Funeral Director: Af death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28a. Piaca of injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital Leavisitying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

Madtcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Cartifias Medicai (Check only ş 29c. Licansa number (1) 17 720 29b. Signatura and titla of certifian 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 1421 S. CATON AVE. BALFO. Md. 21227 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State Registrar NOV 25 1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

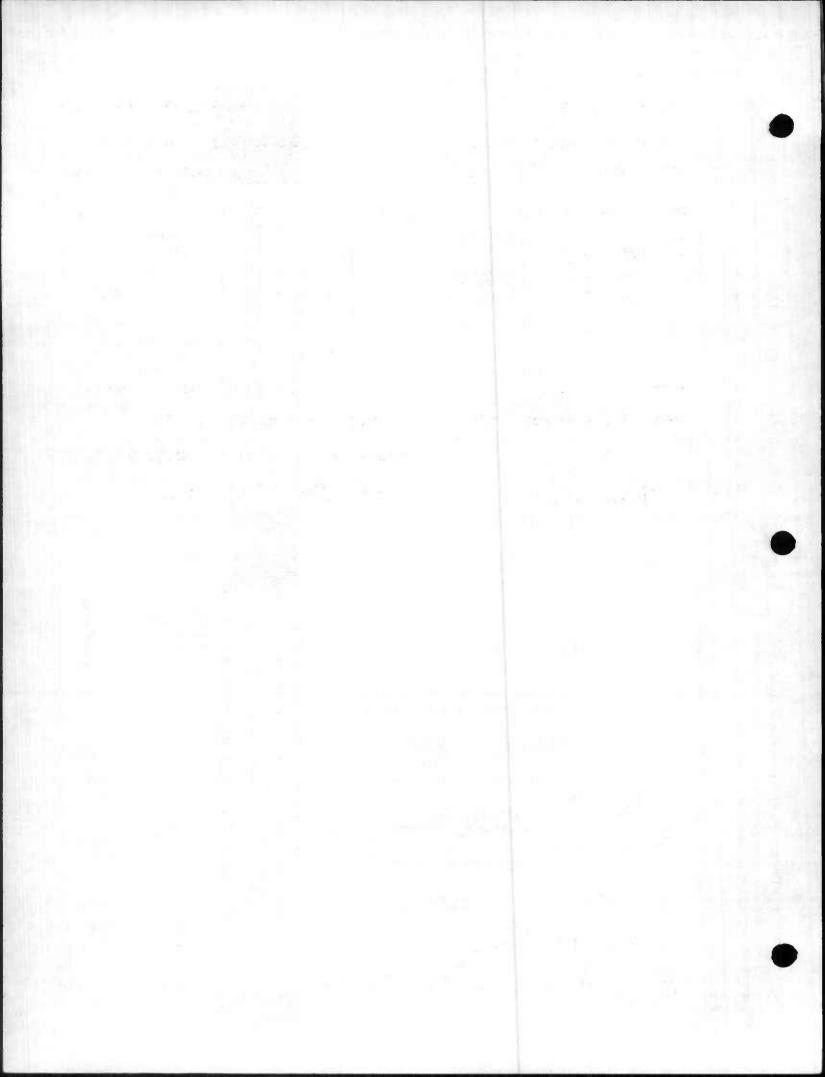
		Certificate of Death	Reg. No.	35560
Physician	1. Decedent's Nema (First, Middla, Last)	/-	2. Dete of Death Month Dey	3. Time of Death
/Medical	JAMES FRANCIS /1	Ayes	November 21	1997 12:35
Examiner	4a. Facility Nama (If not Institution, give street and number)	4b. City, Town, or Loc	ation of Death 4c. County	of Death
	5. Social Security Number 6. Sex 7. Aga (In yrs. I	last birthday) Af Under I Year I If Under 24 Hrs.	Moy S Data of Birth	9. Birthplace (State or Foreign
neral ector	220-18-5414 1RM 20F 92	Yrs. Months Deys Hours Min.	8. Data of Birth (Month, Day, Year) 8-25-1965	Country) (Jirginin
idat	Usual Rasidance of Decedant 10e. Stata 10b. County 10c. City	, Town or Location		10d. Insida City Limits
to	man had NIA	BAltimore		1 Yes 2 No
Directo	10e. Street and Number	/ 10f. Zlp Coda	10g. Citizan of V	Vhat Country?
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Funeral	11. Marital Status 12. Wes Dacedant Evar in U, Armed Forcas?	S. 13. Was Decedent of Hispenic Origin? (Specify Cuban, Maxican, Puarto R	ify Yas or No-	e - Amarican Indian, k, Whitazetc.
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d by	3 Widowed 4 Divorced Yeer or Detes: WW	It	14	MERICAN
Completed	15. Decedent's Education (Specify only highast grade completed)	16a. Dacedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	9	usinass/Industry
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S	17. Father's Name (First, Middla, Last)	18. Mothar's Nama	(First, Middla, <u>Mai</u> den Sumam	
To Be C	Tamos Edward Haves	minni	e Role	18
-	19a. Informant's Name/Relationship (Type, Print) (Color)	19b. Malling Addrass (Street and Number or Rural	Routa Number, City of Town	state, Zip Gode)
	Mr. the dore Borne	4006 Alto Rd. 13 Alti	more and	01216
	2	laca of Disposition (Nama of ematary, cramatory or other place)	Date 20c Location -	City or fown, State
	1 Deurial 2 □ Cremation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify)	orrism Errestihila/	2/01 NW in	5 mill m
8	31. Signeture of Funaral Service Licensee	22. Neme end Addrass of Fecility	NeiAl Hon	e e
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	23a Juril Enter the disaasa, or complications that ceusad the death	a. Do not enter tha moda of dying, such as cardiac or	respiratory arrast,	Approximate
ian	The cause of act in the cause of act in the			Intarval Batween Onsat and Death
ical	Immediate Ceusa (Final disaasa or condition Acute McGV	stratory Fallure 2º Pr	nimom/a	Zurech
iner	resulting in death) Dua to (b)	r as a consequence of):	201.00143	- week
Examiner	b			
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Aedical	rasulting in death) Last	as a consequance of):		
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by	History of Strake & Dome	2ma		
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pie				completion of ceusa of death?
6			1 ☐ Yes 2 ☐ No	1 ☐ Yas 2 ☐ No
Fo Be Comp	25. Was case rafarrad to medical axaminar?	28. Place of Death	(Check only ona)	
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	27. Mannar of Deeth 1 ■ Naturel 5 □ Pending (Month, Day Year)	28b. Tima of 28c. Injury at 28c. Injury Work?	8d. Dascribe how injury occuri	red
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THE ST	3 ☐ Suicida 6 ☐ Could not be determined 28e. Placa of Injury - At ho building, atc. (Spacify,	ma, farm, straat, factory, office 29	 Location (Street end Numb City or Town, Steta) 	er or Rural Routa Number,
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completely filled in by the funeral Medical Certification:	Limit 2 Madical Examinar: On the basis of exeminet	vladga, daeth occurrad at tha time, dete end place, ar ion and/or invastigation, In my opinion, death occurred	nd dua to tha causa(s) and ma d at tha tima, data and placa,	nner as steted. and due to tha cause(s)
Me	one) and mannar stated. 29b. Signatura and titla of cartifiar	29c. License number	29d Deta signer	d (Month, Day, Yaer)
3	1000 mg/m 1000		Abusa	alas 21 100A
7	naving years	1170131	1 vover	1001-1777
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 97

		1. Decedent's Name (First, Midd	dle, Last)			CE	HIHCE	ALG UI	Death	2. Date of D			3. Time of D
Physici	_	Robert Harold 1	Hanso	n						Novemb	er 20	, 1997	0940
/Medid Examir		4e. Facility Name (If not Institution			iber)				4b. City, Town, o	r Location of Dee	1	ounty of Deat	
EAUTH	Ξ.	Anne Arundel Me	edica	l Cent	er				Annapoli	S	An	ne Aru	ndel
Funeral Director		5. Social Security Number 477–07–6992 Usual Residence of Decedent	6. Sex		7. Age (In yrs	lest birthday Yrs.) If Un Month	der 1 Year	If Under 24 H	rs. 8. Dete of B			thplace (State or I buntry) nesota
of show	tor	10e. Stete 10b. Count Anne A		el		ity, Town or L napol:							10d. inside City
23a or 28a-f should be notified at	Funeral Director	10e. Street and Number 851 Yardarm Way	У					Zip Code 1401			10g. Citizen of What Country? USA		
Francher in	þ	11. Marital Stetus 1 Never Married 2 Mar 3 Widowed 4 Divorce	rried	Armed For		J,S. 13.			Hispanic Origin? Dan, Mexican, Pue Specify:	(Specify Yes or N arto Rican, etc.)		I. Race - Ame Black, White pecify: Wh	e, etc.
Department or feath and Mental Hyglene. Important: if item 27 is marked other than "natural;, any injury or other traumatic event, the Medical East once.	Completed	15. Decede (Specify only high: Elementary/Secondary (0-12)	est grade c	tion completed) College (1- 5+	4or 5+)	(Give	DO NO	sual Occu work done Tuse retire	Occupation done during most of working retired)			of Business/	
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Funeral Director: After letely filled in by the fun		29a. Certifier (Check only one) 1 ☐ Cartifyi 2 ☐ Medical	ng Phyeici I Examiner	an: To the bas On the bas and manne	is of examina	tion and/or Ir	nvestigati	on, in my	opinion, death oc	curred at the time	, date and p	laca, end due	to the cause(s)
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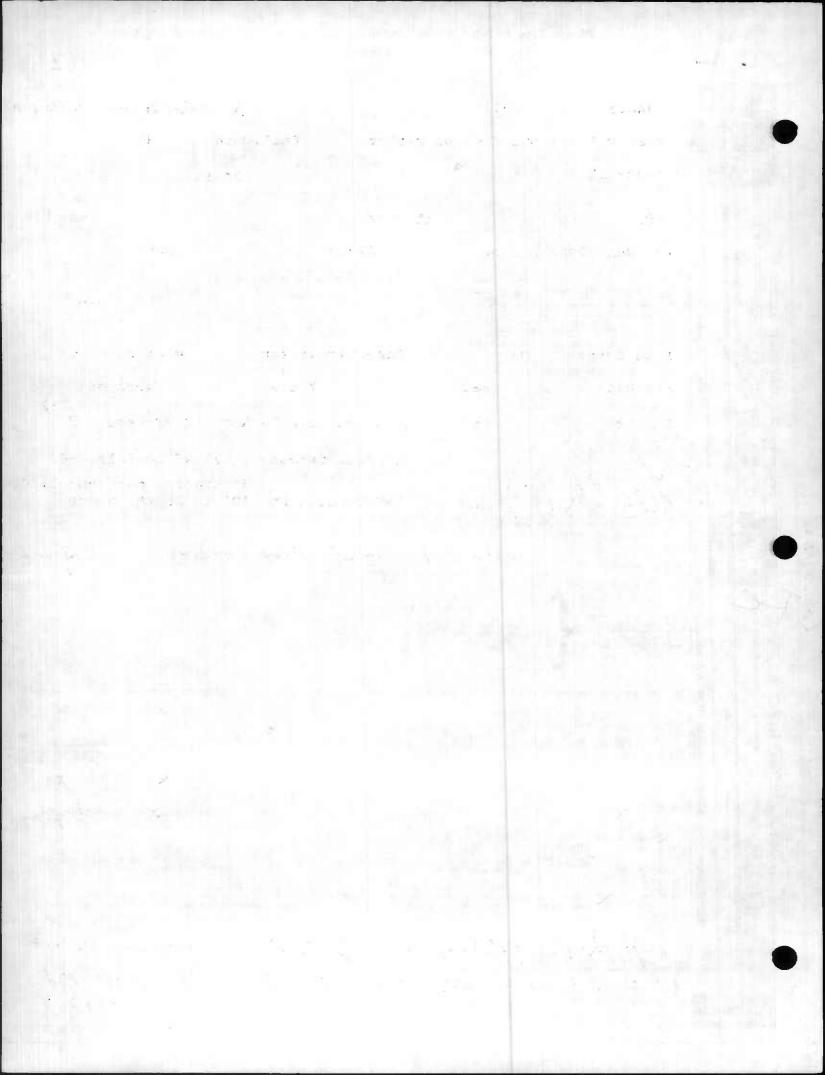


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Day Yaar **Physician** 1997 3:45 PM Lenora Hall November 21 Medical 4c. County of Death 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical center Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days 1 M 2 F 69 214-24-1551 Director Md Usual Rasidence of Dacedant the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show notified at ¥QYes 2 No Director Md. Na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7 is marked other than "natural", or itema 23a or traumatic event, the Modical Examinar must be 21218 123 West 29th Street USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐No If Yes, Giva Yaar or Dates: 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, While, atc. 1□Navar Married 2□ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry d 2 should be filed within 73 th and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) Collaga (1-4or 5+) 10th Grade NA Domestic worker various trade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths any Injury or other traumatic event. 17. Fathar's Nama (First, Middla, Last) 18 Mothar's Nama (First Middle Maiden Sumame) Be Hall Francis Viola Northern 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) 21286 19a. Informant's Name/Ralationship (Type, Print) Hall 16 Airway Circle Apt. "1D" Towson, Md. Lester 20b. Plece of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Voshell Mem. Gardens 11-25+97 Dundalk, Md. 4 □ Donation 5 □ Othar (Specify) 21. Signifium of Funeral Service Licen 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Part 1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one eause on each line. Approximate Interval Batween Onsat and Daath **Physician** metastatic gall Bladder concer /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Ceusa (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) the burial Box 68760 Physician/Medical Due to (or as a consequence of) as 0 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? the signed by the 3 Probably 4 Unknown 1 Yes 2 No by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed peen complation of causa of daath? 1 ☐ Yas 🏖 No 1 ☐ Yas 2 No certificate of Vital director, 25. Wes case referred to medical exeminer? Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOSPICE 2 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this To the Hospitarch Attending Ph within 24 hours stier fostin To the Euleral Director. After this completely fulled in the the file funeral 27. Menner of Death 28e. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Division 5 Panding invastigation 1 Neturel 2 ☐ Accidant 1 Yes 2 No 6 Could not be datarminad 3 ☐ Suicida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred et tha lime, data and place, end dua to the ceusa(s) end menner es stated.

Medical Examinar: On the basis of exeminetion and/or invastigetion, in my opinion, daath occurred at tha tima, deta end place, and dua to the cause(s) and manner stated. 29a. Cartifier Medical 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature agd title of certifier w 30. Nama and addrass of person who co tam 23a) (Type, Print) 6701 N. Charles St. Bolto, and R: 32: Pagiturar's Signatura 31. Dete filad (Month, Day, Yeer) State NOV 2 5 1997

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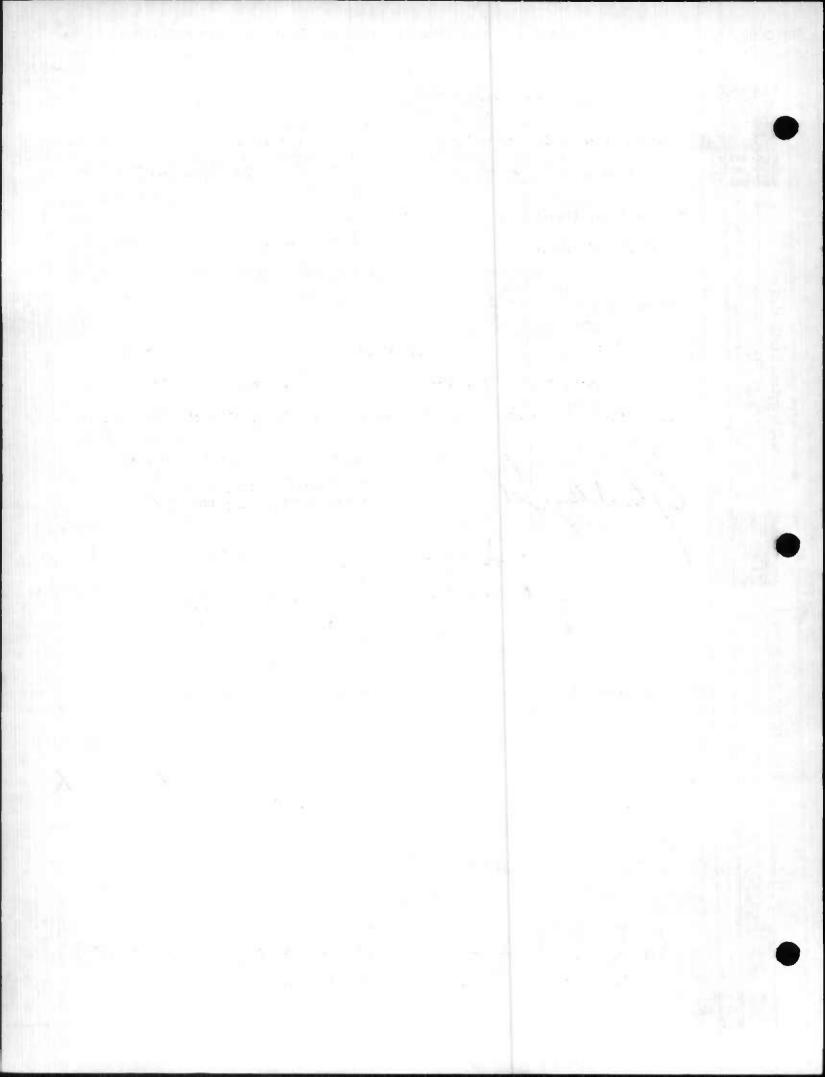
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at be notif	Funeral Director	10e. Street end Number 98 Smithwood Aven	iue			10f. Zip Cod	de	21228		10g. Citizen of	Whet Coun	Iry?
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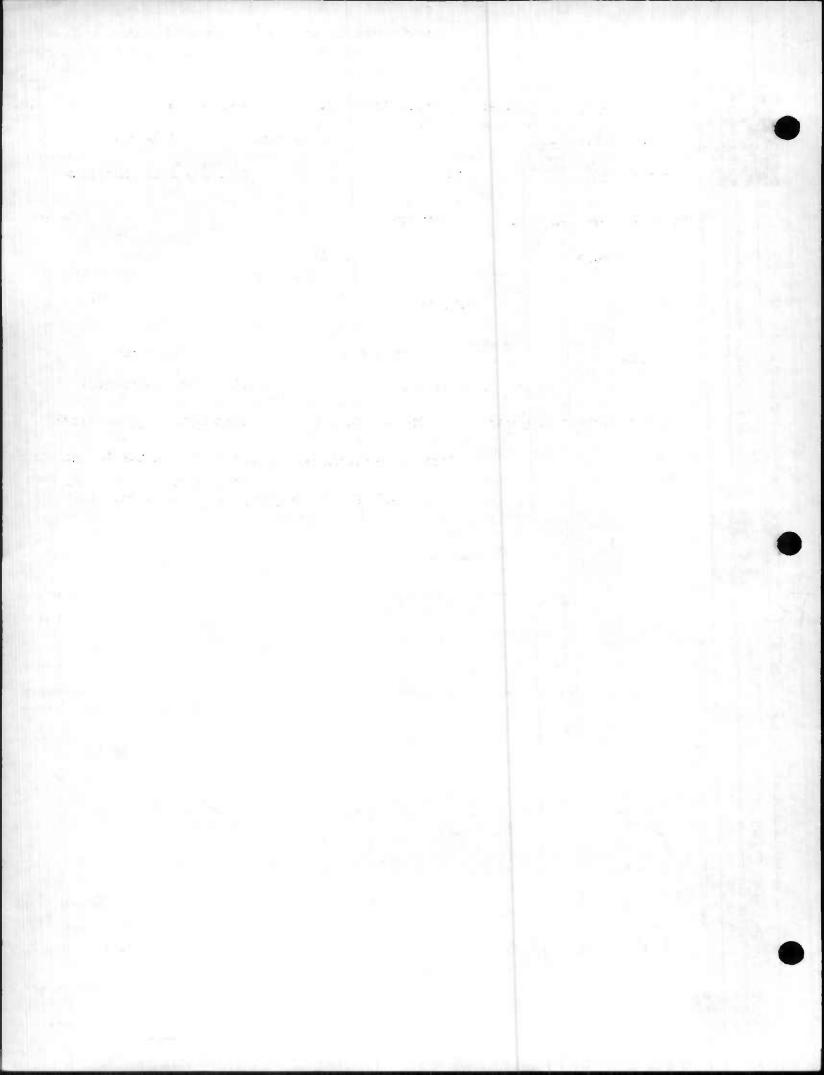
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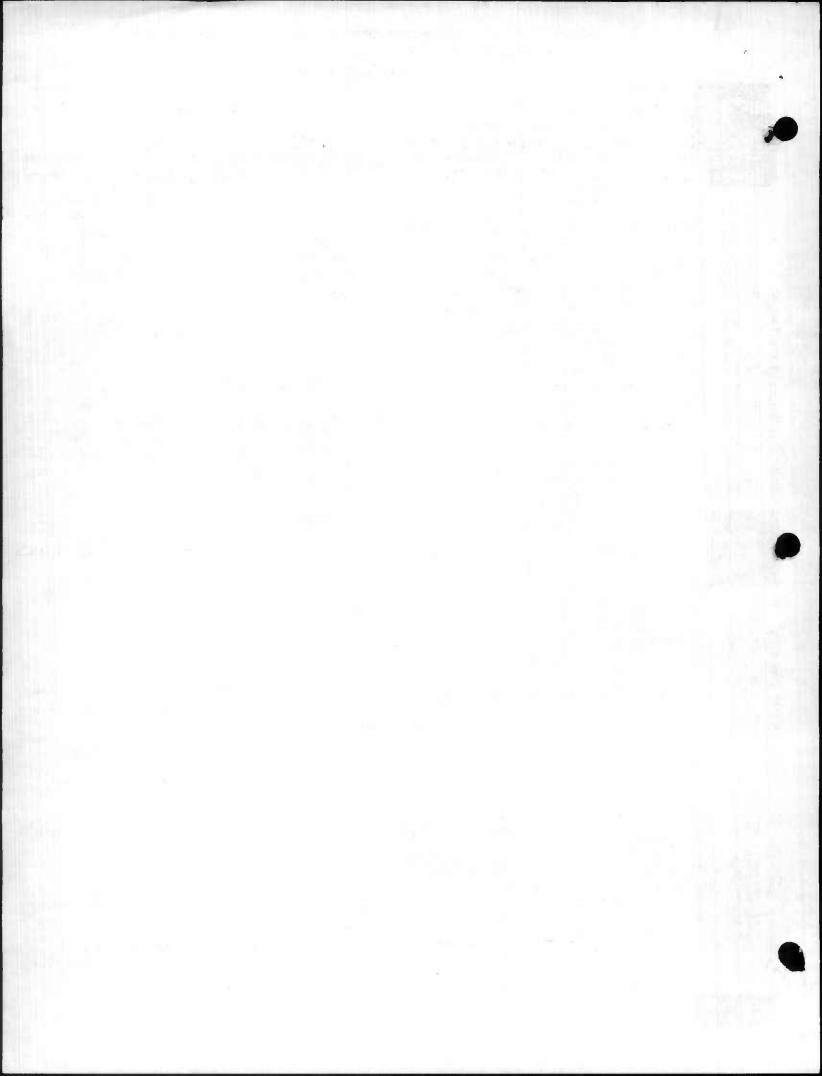
State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



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	4	VA Maryland 1 5. Social Security Number		are S 7. Age (In yrs.		If Under 1 Ye	BALTIN ar If Under 24		inth /	A Righteless (State o	e Eoroia
ral tor		214-14-3156	1) M 2□ F	75	Yrs.	Months Day		Min. (Month, L	Dav. Year)	9. Birthplace (State of Country) PENNSYLUM	2/2
	- 1-	Usual Rasidence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loc	cation				10d. Inside Ci	ty Limits
2	5	narylon P	10		BOLT	THUTE				12XVes	2 N
Funeral Director	5	10e. Street and Number				10f. Zip Code	•		10g. Citizen of V	Whet Country?	
200	el ai	4716 Norfolk	AUGNUE 12. Was Dece		10 10 10		1207	2 (Casalta Vas as A	- 1000	ce - American Indian,	
2	2	11. Marilel Status 1 Never Merried Marrie 3 Widowed 4 Divorcad	Armed For	ces? 2 No // -	-50	Yes, specify C		n? (Specify Yes or N Puerto Rican, etc.)		ck, White, etc.	
peter	פופר	15. Decadent' (Specify only highest	s Education			ent's Usual Occ	cupetion ne during most o ired)	f working	16b. Kind of Bi	usiness/Industry	
Completed	2	Elemantary/Secondary (0-12)	College (1-	4or 5+)		ONOT use rati	ired)		siness		
a		17. Fether's Name (First, Middle, L			7077.0			Name (First, Middle	la, <i>Maiden Sum</i> an		
L C		Roger Smile			10h Maitin	a Addrage (Stre	Ruth Lorkins Street and Number or Rural Route Number, City or Town, Stata, Zip Code)				
		HILDA JOHNSON Wife 4716 Norfolk Dus									207
	1	20a. Method of Disposition 1 Surial 2 Cremation	Date 11-18	20c. Location	- City or Town, State 19 5 Mills, 10 Mills, 10 Mills,	n					
9	-	4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		Gm	75M 70V	Name and Add	tress of Fecility	SANTHAN	- Harn	s Funeral A	om
		Array Ha	ruis		50	40 RC	& Ma	rulaxo	31215		
edicai Examiner	Evalline	disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseases or injury that initiated evants resulting in death) Last	е	Dua to (or as a consequence or as e consequence or as e consequence or es a consequence or established o	uence of):	1				
			d			·					
/ Physician/M		Part II. Other significant condition	s contributing to dea	ath but not res	sulting In the un	derlying cause	given in Part I.		Yee 20 No	ontribute to the cause of 3 ☐ Probably 4 ☐	
Completed by								24a. Wa	s en autopsy formed?	24b. Were autopsy f evailable prior to completion of c of deeth?	0
								10	Yes 2000	1 □ Yes 20	No
Be C	1	25. Was case rafarrad to medical examiner? 1 Yes 2 No	Hospital:	/			Whor	t Death (Check only			
n: To		27. Manner of Deeth	28a. Date o		28b. Time ot	3 □ DOA 3 28c. tn	4 🗆 IAUISI	ing Home 5 Re	sidence 6 LIOth how injury occur		
Certification:		1 Natural 5 Pending investige 13 Suicide 4 Homicide	ot be 28e. Place		ome, tarm, stre		☐ Yes 2☐No	28f. Location	(Street and Numbown, Stata)	ber or Rural Route Num	ber,
E.	<i>!</i>	29a. Cartifiar Certifying	Physician: To the base	sis of examina	wledge, death	occurred at the estigation, in m	time, date end p y opinion, deeth	place, and due to the occurred et the time	a cause(s) and ma e, data end placa,	anner as stated. and dua to the cause(s)
		one)	and the stripes see			I	Man aumban	1	20d Date signs	d Adonth Day Vasal	
Medical Certi		29b. Signature end title of certifier		_		290. Lice	N T	000	////	d (Month, Day, Year)	
edicai	2		no complated cause			rint)	-N7	000	11/1	21201	_



Physician /Medical

Examiner

Funeral

Director

Funeral Director

Completed by

Be 2

Please	Type or Print in Bla	ack Indelible In	k. Assure A	II Coples Are Legi	ible.
	State of Maryland	/ Department of	Health and M		7 35566
		Certificate of	f Death	Reg. No.	
1. Decedent's Name (First, Middle, Last, Johnnie		hnson		2. Date of Death Month Day NOVLMINEY 20 19	3. Tim ft th
4a. Facility Name (If not institution, give			4b. City, Town, or Lo	ocation of Death 4c. County	of Death
5. Social Security Number 6. Sa. 230-16-3497	7. Age (In yrs. lest	birthday) If Under 1 Yea Yrs. Months Day		8. Date of Birth (Month, Dey, Year)	9. Birthplace (Stata or Foraign Country)
Usual Residence of Dacedant 10a. Stete 10b. County	10c. City, T	own or Location			10d. Inside City Limits
Md. NIA	F	altimor	و ا		Yes 2 No
10e. Street and Number		10f. Zip Code		10g. Citizen of V	What Country?
922 Newingt	on Avenue	2, 2	1217	11.5	i A
	12. Was Decedent Evar in U,S. Armed Forces?	13. Was Decedent of	f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No-	ce - American Indian,
1 Never Married 2 Married	1 Yes 2 No				ck, White, etc.
3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 Yes 2 No		Specify	Hami
15. Decedent's Edu (Specify only highest gradi Elementary/Secondery (0-12)	loation le complatad) College (1-4or 5+)	 Decedent's Usual Occi (Give kind of work don life. DO NOT use retir 	e during most of worki	ing	usiness/industry
11 th grade	College (1-401 34)	TRUCK	Driver	Charles	Gladden Trucking
17. Father's Name (First, Middla, Last)			18. Mother's Name	e (First, Middle, Meiden Sumen	na)
unknown			Low	se Hollow	way
19a. Informant's Name/Relationship (Ty		9b. Mailing Address (Street	et end Number or Rura	al Route Number, City or Town,	, Steta, Zip Code)
Rodney Jone		22 Newin	igton Au		ne, Macyandrial 7
20a. Method of Disposition 1	Removal from State	of Disposition (Name of efery, crametory or other pi		Date 20c. Location	- City or Town, State
21. Signature of Funeral Service License		210N CET	METERY II	-20-71 LANDS	DOWNE MD.
N 21	1.00	Joseph H	F. BROWN	JR Funeral Ho	ome PA.
Charron To	1. Doykins	2140 N. F	ilton Aven	we Baltimes	Meybrol 21217
23a. Part1. Entar tha disease, or complishock, or heart failure. List only or	ications that coused the death. Ene cause on each line.	to not enter the mode of dy	ying, such as cerdiac o	or respfratory arrest,	Approximete Intervel Between Onset and Death
Immadlate Cause (Final disease or condition	METASTIC	PROSTAT	E CANCE	en	v 2 years
resulting In death)	1.	a consequence of):			
		a solitor decise of.			
Sequentially list conditions, if any, leeding to Immediate	Due to (or as	a consequence of):			
Cause (Disease or trijury that initiated events	Due to for so	The second of the			
resulting in death) Last	Due to (or as	a consequence of):			
	1				
Part II. Other significent conditions con	ntributing to death but not resulting	a in the underlying ceuse g	siven in Part I.	23b. Did tobacco use co	intribute to the cause of death?
				1□Yes 2⊠No	3 Probably 4 Unknown
				0.4	Cath Mass subspay findings
				24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 BiNo	1 ☐ Yes 2 ☐ No
25. Was cese referred to medicel examinar?				h (Check only one) Stell	a Maris at Mercy
1 ☐ Yes 2 No	fospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA	ther:	ma 5 Residence 6 Doth	ner (Specify) HOSPICE
27. Menner of Death			4 Li Nuising not	THE SCHOOLOGICS OF CALL	iei (Specify)
1 Natural 5 Pending Investigation	Tarrier I	b. Time of lnjury 28c. Injury W	ury at ork?	28d. Describe how Injury occur	11 11

The law requires that the death certificate be elec-Division of Vital Records, P.O. Box 68760, is certificate has been signed by the allending physicien director, page 2 should be detached for use as the buris.

Physician

/Medical Examiner

> Physician/Medical Examiner þ Completed Medical Certification: To Be

29a. Certifier (Check only one)

To the Hospital or Attending Physician: The law within 24 hours after death.

On the Furneral Director: After this certificate has it completely filled in by the funeral directors gas 2 s filled in by the funeral

State Registrar 29b. Signature and title of certifier Ju Donous

FERNANDO

31. Date filed (Month, Dey, Year) NOV 2 5 1997

7672 BEZAIR RD 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BALTO. MD 21236

pccrtifying Phystclen: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

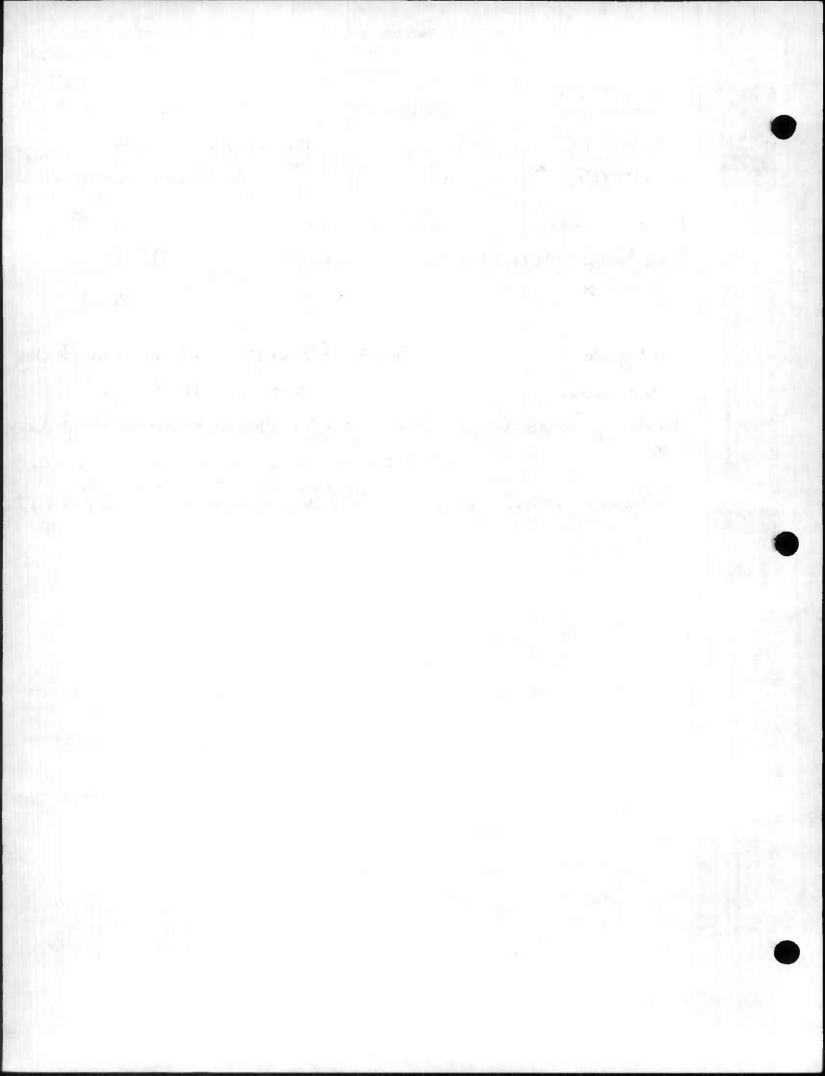
29c. License number

D40480

29d. Date signed (Month, Dey, Yeer)

November 20, 1997

32. Registrar's Signature



LEANTO A	۱ . د				larylar		rtificate of	Health and I f Death		giene 9	7 3	5567	
Physic /Med		Decedent's Nam		Antonio	Johr	nson			2. Date of De Month NOVEMB	Dey	Yeer 1997	3. Time of Death 0150AM	
Exam				re street and number,		1-1		4b. City, Town, or I	ocation of Deet	Deeth 4c. County of Deeth			
		FRANKLIN 5. Social Security N		HOSPITAL E		1 1111 1 1	If Under 1 Year	ESSEX If Under 24 Hrs.				ORE COUNTY	
Funera Directo		215-84	-6373		ge (in yrs.	last birthday) Yrs.	Months Days		8. Date of Birth (Month, Dey, Year) 12-14-75			Birthplace (State or Foreig Country) Md.	
D &		Usuat Residence of	Decedent 10b. County		10a Cia	y, Town or Lo							
Maryla P-f show	Director	Md.	NA			altimo						10d. Inside City Limits N☐XYes 2☐ No	
h th	ire	10e. Street end Nur	mber				10f. Zip Code		10g. Citizen of Whet Counfry		nfry?		
h wit		729 Ar	gonne D	rive		21218				US	A		
21215-0020 d within 72 hours efter death with the Maryland plane. It then "natural", or items 23s or 28s-f show in the hearter in the neather and the notified at	by Funeral	729 Argonne Drive 11. Marital Stetus 12. Was Decaden Armed Forces 1 Yes 2 If Yes, Give Year or Dates			?		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 No	Hispenic Origin? (Saban, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. R	aca - Americ leck, White,		
72 hours	Completed	15. Decadent's Education (Specify only highest grede completed)				16e. Dece	dent's Usual Occu	upetion e during most of wor red)	king	16b. Kind of	Business/In	dustry	
within ane.	mpi		nentery/Secondary (0-12) College (1-4or 5+)										
		10th grade NA 17. Fether's Neme (First, Middle, Last)			-	Machine Operator			o /Eirot Middle			corporate	
and be and o be and o	To Be	Humphr		Johnson	, Sr			Claret		Scott	ente/		
more, Maryl Pages 1 and 2 shouk tent of Health and Me ntt if Nem 27 te mark by or other trainmail.			ha Jo	hnson	C	729 Ptace of Disponentery, cres	Argonn esition (Neme of metory or other pl		Baltim	ore, M 20c. Location	aryla n - City or To	and	
Departit Departit Importa any inju	(Talin	neral Service Licer	Den	,	22 V		ress of Facility E arch FH	altimo	re, M	aryla	dallstown and 21202 venue	
Physician /Medical Examiner		Immediate Ceuse (disease or condition resulting in death)	rt tallure. List only	plications that cause one cause on each to	d the death	h. Do not ent		ying, such as cardiac		rrest,		Approximate Interval Between Onset end Deeth	
D Parities	aminer	Sequentially list cor	nditions	b.	Due to (o	r as a consec	uence of):						

Division of Vital Records, P.O. Box 68760 tha 98 USB

Exar Physician/Medical by Completed Be

3 Suicide

30. Name and

4 Homicide

s cartificate has been signe director, paga 2 should be this

29a. Certifier (Check only one)

Medical Certification: To 29b. Signature an

To the Hospital or Amending I within 24 hours after death To the Funeral Director After

State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest

Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatlent 3 ☐ DOA 1∰ Yes 2□ No 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 1 Naturet 5 Pending 2 Accident

Investigation 6 Could not be determined

28e. Plece of Injury - At home, ... building, etc. (Specify)

28b. Time of injury 0120

At home, farm, street, factory, office

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Ed 28f. Location (Street end Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed?

1 Ves

28d. Describe how injury occurred

2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

O.C.M.E.

29c. License number

29d. Date signed (Month, Dey, Year) NOVEMBER 22, 1997

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

24b. Were eutopsy findings aveilable prior to completion of cause of death?

1 Yes 2 No

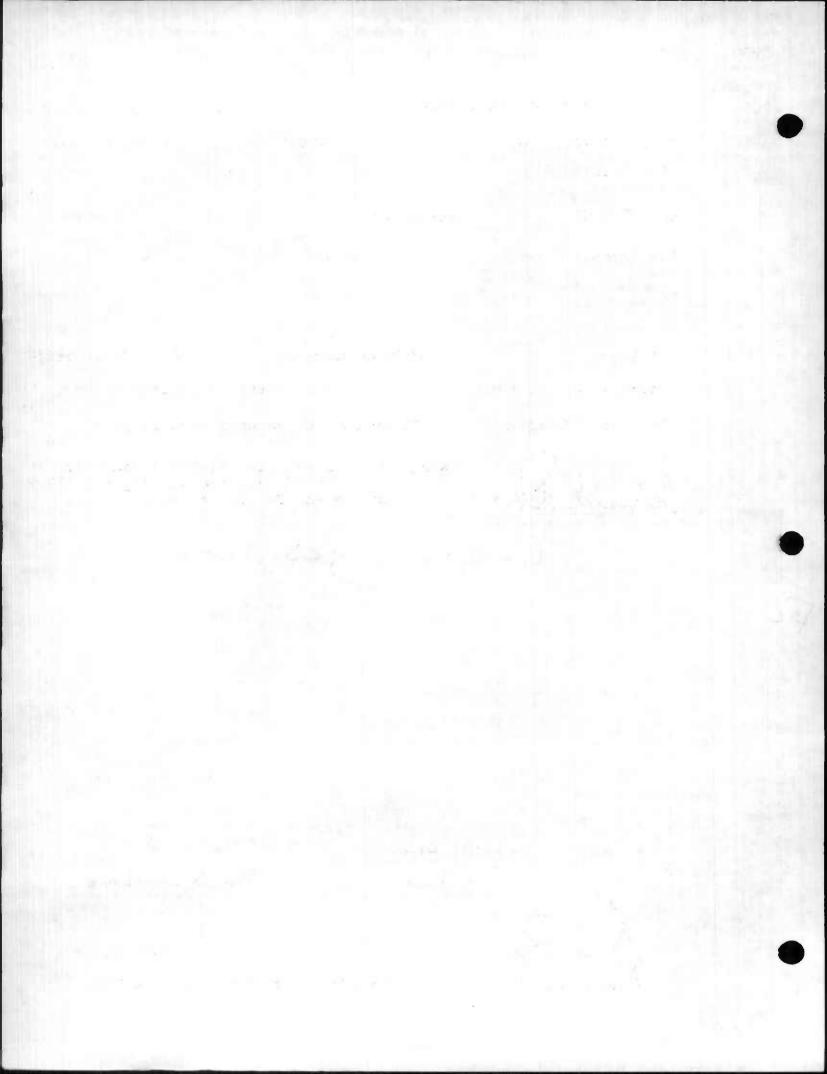
to completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

26. Place of Death (Check only one)

31. Date fited Registrar's Signature

his Davidson-Randell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death NOVEMBER 18, 1997 **Physician** KATHERINE JARVIS 4:05 AM /Medical 4b. City, Town, or Location of Deeth 4a. Eacility Name (If pot institution, give street and number)
Saint Joseph Medical Center 4c. County of Death **Examiner** Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□XF Yrs. Director 216--44-6616 83 April 26, 1914 Pennsylvania Usual Residence of Decedent the Manylend 10a Stete 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow 7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Moulcal Examinat must be notified at Harford 1 ☐ Yes 2 ☑ No Director Maryland Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 Philadelphia Road 21085 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 72 hours after 1 XYes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify by 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene Important: If Item 27 Is marked other than "nany Injury or other traumatic avant Elementary/Secondery (0-12) College (1-4or 5+) 12 Registered Nurse U.S. Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be John Stager 2 Mary Markle 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Klausmeier (Niece) 4100 Walter Avenue Baltimore, Maryland 21236 20b. Plece of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20e. Method of Disposition 1 XBurlel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. November 21, 1997 Baltimore, Maryland 22. Name end Address of Facility E.F. Lassahn Funeral Home, P.A. 21. Signature of Funerel Service Licensee 23e. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feliure. List only one cause on eech line. 11750 Belair Road Kingsville, Maryland 21087-1351 Approximete Intervei Between Onset end Death **Physician** MULTI ORGAN FAILURE /Medical Immediate Ceuse (Finel disease or condition resulting In death) **Examiner** Due to (or es e consequence of): SEPSIS physician and s the buriel-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequenca of): PSEUDOMEMBRANOUS COLITIS Box 68760 certificate be Physician/Medical Due to (or es e consequenca of) θS attending for use es signed by the a P.O. | Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No STATUS POST COLECTOMY Records, þ 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed peed STATUS POST NEPHROURETERECTOMY hes page 1 ☐ Yes 2 No 1 Yes 2 No After this certificate Division of Vital Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: the Hospital or Attending 5 Pending investigation 1 Natural within 24 hours efter deeth.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) end manner stated.

1 title of certifier For Def F. P. College Deeth Colleges number 29d. Date signed (Month, Day, Year) 29a. Certifier Medicai (Check only 29b. Signature and title of certifier 70

7601 YORK ROAD TOWSON, MARYLAND 21204

State Registrar

ALTONSO P.

31. Date filed (Month, Day, Year)

NOV

30. Name end address of person who completed ceuse of deeth (item 23e) (Type, Print)

2 5 1997

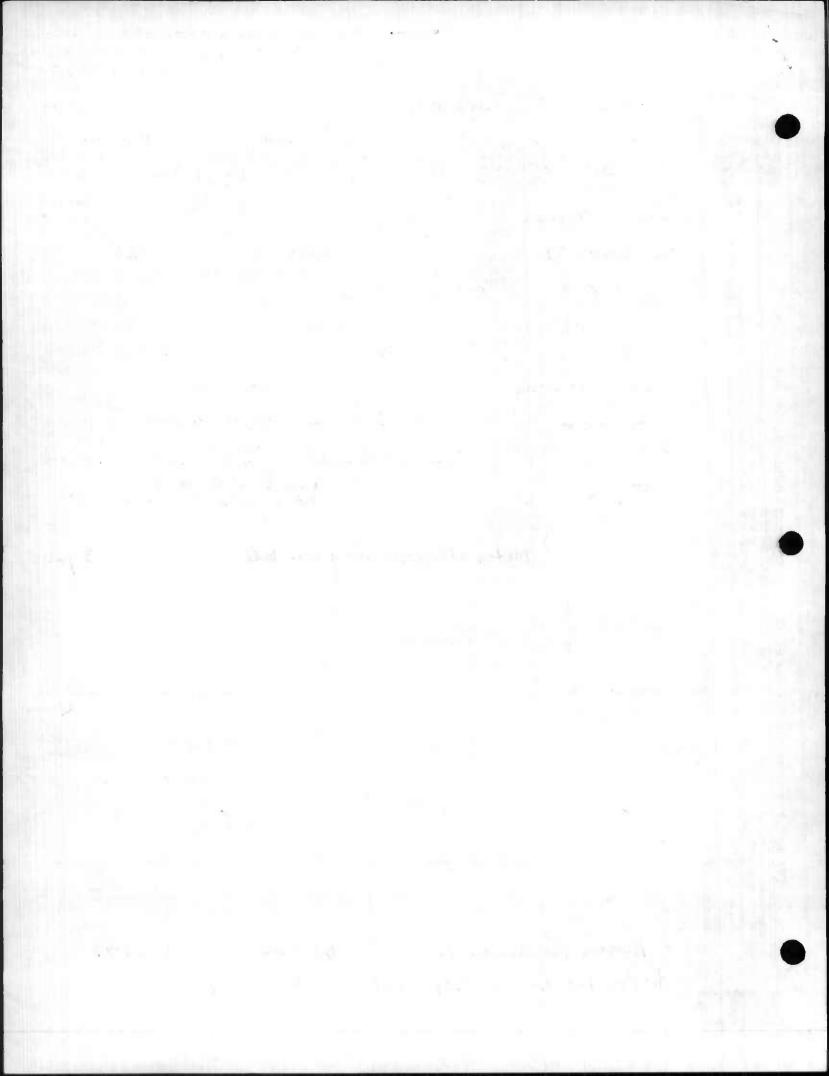
ZALDUONDO, M.D.

32. Registrar's Agneture Jundson-Randell

Done or seem Medical Lorence Topicon

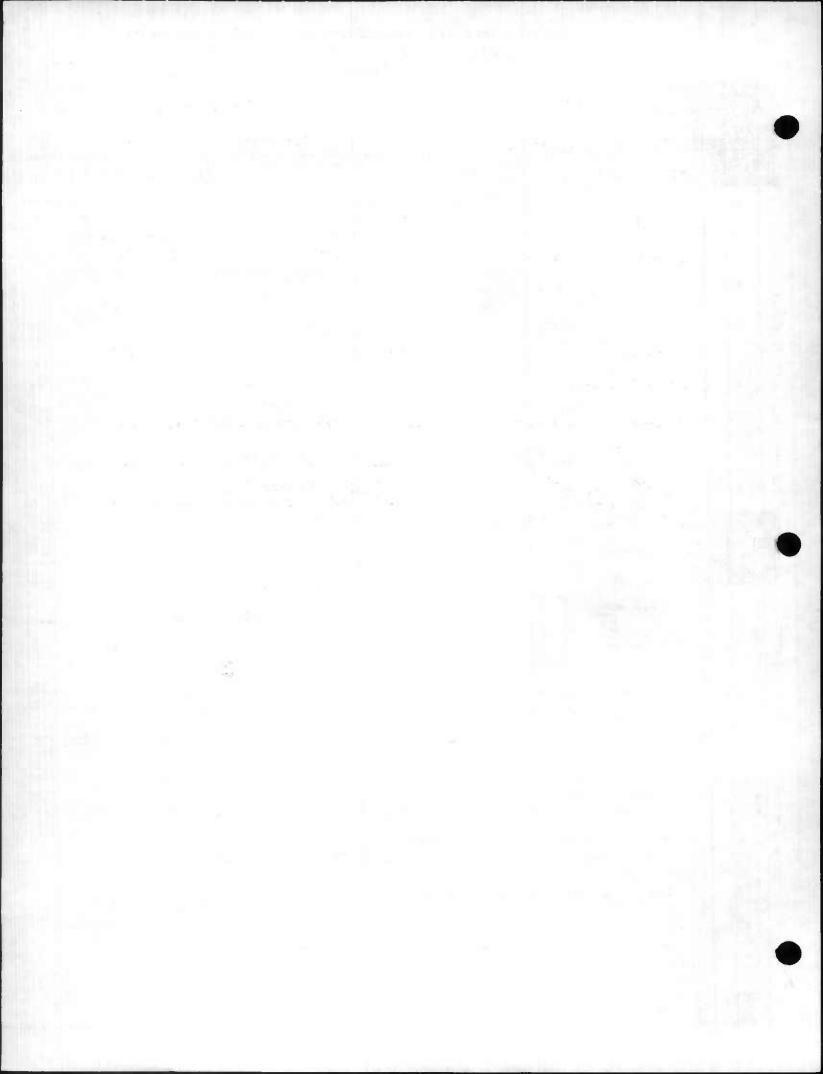
State of Maryland / Department of Health and Mental Hygiene

	ian	1. Decedent's Nama (First, Middla, I		donski	500		2. Data of De Month	Day	Yaar	Tima of Deeth
/Medi	cal	4a. Facility Nama (If not institution, g		aoriski		4b. City, Town, or	November		.1.	:00 AM
Exami	ner	2422 Bradford				Carne			altimor	
Funeral Director		5. Social Security Number 6. 217 07 3580 Usual Rasidance of Decedant	Sax 1.2 M 2□ F	(In yrs. last birth	day) If Under 1 Year Months Days		8. Data of Bin	th ay, Year) 7 1914	9. Birthplaca Country)	State or Forei
show		10a. Stata 10b. County		10c. City, Town					10d. Ir	sida City Limi
28a-f sho notified at	ector	11110	more	EA	rney				1 ☐ Yas 2 ☑	
23a or	Funeral Director	10e. Street end Number 2422 Bradford	zd.		10f. Zip Code	21234		10g. Citizen of W	That Country?	
al', or items Examiner m	by Fune	11. Marital Status 1 □ Navar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Ev Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:		13. Was Decedant of If Yas, specify Cub 1 ☐ Yas 2 ☑ No		pecify Yas or No o Rican, atc.)	9- 14. Race Black Specify.	a - Amarican In k, White, atc.	dlan,
natur	Completed	15. Decedant's (Spacify only highast g		16a. C	Decedant's Usual Occu Giva kind of work dona lifa. DO NOT usa retire MAChinis		king	16b. Kind of Bu		
Department or result and wester hyperanal important: If item 27 is marked other than 1 any injury or other traumatic event, the Ma once.	To Be Co	17. Fathar's Nama (First, Middla, Las	donski		1 //Critini	18. Mothar's Nar	1	Maidan Sumami	a)	
Is ma		19e. Informant's Name/Relationship		19b. I	Mailing Address (Stree	n. 1				
if Item 27 is or other tra		Mary Kordonsk 20a. Mathod of Disposition 1 Burlal 2 Cramation 3		20b. Placa of C	Disposition (Nama of cramatory or other pla		Data, November	1Ary And		itata
important: If its any injury or of once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	ify)	Sacred +	teart of Jes		26 1997	Dundal	K , MA	ryland
important in portant i		23a. Part1. Enter the disease, or coshock, or heart fellura. List onli	L		22. Nama and Addra	Evans Cl 8800 Hart	a. a. harf.	Memorits Baltimore		234
g physician and es the bunal-transit	ai Examiner	Sequantially list conditions, if any, leading to immediata cause. Entar Undarlying Causa (Disaasa or Injury that initiated avants	a. Metast	ua to (or as a co	,					
(A) (B)	Medicai	that initiated avants rasulting in death) Last	D.	ua to (or as a co	nsequance of):					
	ian		u .						1	
	Physician/	Part II. Other significant conditions		not rasuiting In t	ha undarlying causa gi	van in Part I.		tobacco uee con Yaa 2⊡ No		
is been signed by the attandin 2 should be detached for use	by Physician/I	Part II. Other significant conditions		not rasulting In t	ha undarlying causa gi	van in Part I.	1 □		3 Probably 24b. Wara au available	Unknown topsy finding a prior to ion of causa
is been signed by the attandin 2 should be detached for use	Completed by Physician/			not rasuiting In t	ha undarlying causa gi		24a. Was	Yaa 2□ No an autopsy rmad? Yas 2☑ No	3 Probably 24b. Wara a available complet of death	Unknown topsy finding a prior to ion of causa
is certificate hes been signed by the attandin director, page 2 should be detached for use	Be Completed by Physician/	Part II. Other significant conditions 25. Was casa raferred to medical axaminar? 1			0	26. Placa of Dec	24a. Was perfe	Yaa 2□ No an autopsy rmad? Yas 2 Ø No ona)	3 Probably 24b. Wara at available complet of death 1 Yas	utopsy finding a prior to opi or of causa ?
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7

		1. Decedent'e Neme (First, Middl	e, Last)		- 1		of Death	2. Dete of Dec		Maria	3. Time of	Deeth
Physic /Medi		Zina Mary Ki	ng					Novembe	r 78, 1	997	12:00	P.M.
Exami		4e. Fecility Neme (If not institution	n, give street and num	iber)			4b. City, Town, o	r Location of Deeth				
		3754 Ravenwood	l Avenue				Baltir			/A		
Funeral Director		5. Sociel Security Number 212-28-3229 Usuel Residence of Decedent	6. Sex 1 M 2 1 F	7. Age (In yrs	: last birthday) Yrs.	Months D	ear If Under 24 Ho eys Hours Min	s. 8. Dete of Bird Month, De July 17	h y. Year) , 1932	Coun	lece (Stete or in) Kand	r Foreign
land land		10e. Stete 10b. County		10c. C	ity, Town or Lo	ocation				10	0d. Inside Cit	y Limits
ath with the Marylan 23e or 28e-f show	to	Maryland	N/A		Ва	ultimor	ρ.				1 X Yes	2 No
th the	Directo	10e. Street end Number				10f. Zip Co			10g. Citizen of V	Whet Coun	try?	
th will	al	3754 Ravenwood	Avenue			21	213		u. s.	A.		
72 hours efter death with the Maryland naturel; or items 23s or 28s-f show deal Examiner must be notified at	by Funeral	11. Maritel Stetus 1 ☐ Never Merried 2 (※ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Yeer or Da	ces? 2 🔯 No		Wes Decedent If Yes, specify 1 ☐ Yes 2 🛣	of Hispanic Origin? (Cuben, Mexican, Pue No Specify:	Specify Yes or No- rio Rican, etc.)	14. Rec Bled Specify	e - America ck, White, c		
2 hor		15. Deceden	's Education		16e. Dece	dent's Usuel O	ccupetion		16b. Kind of Bu			
ed within 7 giene. er than "n t, the Wed	Completed	(Specify only highes Elementary/Secondary (0-12) 12th Grade	College (1-	4or 5+)		kind of work d DO NOT use n memake	ccupetion one during most of w atired)	orking	Own	Home		
tal H	Be (17. Fether's Name (First, Middle,					18. Mother's Name (First, Middle, Malden Sumeme)					
Man Man mrke mrke	10	Russell Lumpkin					Mari	g Garrasi				
l 2 sh n and is m		19e. Informent's Name/Reletions					reet end Number or i				,	
Healt Healt Ber		William H. King 20e. Method of Disposition	(Husbana)				ood Avenue	Dete Dete				3
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Depa Impo Impo any it		21. Signature of Funeral Service 22. Part 1. Enter the disease, or shock, or heart tailone. List		used the dee	3	Schimun 3331 Br	ddress of Fecility ek Funeral ehms Lane, dving, such es cardi	Baltimo	re. Mar	yland	21213 Approximate	
Physician /Medicai Examiner	i	Immediate Ceuse (Final disease or condition resulting in deeth)			or es e consec						Onset end D	veen Deeth
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g physician and as the buriel-tran	Exa	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	Ash	nosole		quence of):	any Vasco	ular D	seise	1	~8 3	and and
	Physician/Medical	Cause (Disease or Injury that initiated events resulting in deeth) Lest	c		or es e conseq						, ,	
ed for u	sicis	Pert It. Other significant condition	ns contributing to dee	th but not re:	sulting in the u	nderlying caus	e given in Part I.	23b. Dld t	obacco use co	ntribute to	the cause of	f death?
been signed by the attandir should be deteched for usa	by Phy		sunosi						Yes 2□No			
10	Completed							24a. Was perfo	an autopsy med?	COL	re eutopsy fir illable prior to appletion of ce leeth?)
The law r cate has b paga 2 st	Co							1 🗆 Y	es 2 No	1 🗆	Yes 2 n	No
Physician: this cartific ral diractor,	Be	25. Wes case referred to medical exeminer?	Hamital					eath (Check only o	ne)			
Physician: The la r this cartificate has aral diractor, paga 2	10	1 Yes 2 No 27. Manner of Death			ER/Outpetien			Home Sesio)	
ie the Mospital of Attending Ph within 24 hours attendash. To the Funerei Director: After th completely filled in by tha funeral	Certification:	1 Netural 5 Pendin 2 Accident investig 3 Suicide 6 Could r	ation of be	, Dey Year)	28b. Time of Injury	М	Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe h				
urs after rei Direc illed in by		4 Homicide determ	bullding	g, etc. (Speci	(ty)	eet, fectory, of		City or Tow				
- Hosp 124 ho Fune letely fi	edical	29a. Certifier (Check only one) Certifying 2 Medical I	g Physicien: To the b Examiner: On the bas end manne	est of my kno ils of examine or steted.	owledge, death etion and/or inv	n occurred et the vestigation, in r	e time, date end pled ny opinion, deeth occ	e, end due to the curred et the time, o	ceuse(s) end me date and pleca, o	nner es ste and due to	eted. the ceuse(s)	
withir To th comp	W	29b. Signeture end title of certifier				29c. Lic	cense number		29d. Dete signe	(Month, L	Dey, Year)	
-		07	my	Ms						,		00 -
	-	30. Name end eddress of person v					DYOUR 1672 Ber BALTO		Novem	bes	19, 19	777



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle Last) 2. Dete of Deeth **Physician** 1:35 EM Charles J. KlArMAN NOV 21 97 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BAltimore BAltimore BAltimore VA Medical Center If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funerai** Deys Months 1₩ 2□F Director 212-01-5821 83 Sept 23, 1914 Maryland Usuel Rasidance of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Menyland Department of Heelth and Mental Hyglena. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show important: If item 27 is marked other than "naturel", or items 23s or 28s-f show in Injury or other traumatic event, Ins Medical Event instrume man be notified as 10e. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits ir than "naturel", or frems 23s or 28s-f short the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Upperco 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 16001 Trenton Rd. Funeral 21155 USA 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 253 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) Balck & Decker 12 years Tool & Die Maker Manufacturing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 2 Frank Klarman Catherine Miles 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Louise E. Klarman (Wife) 16001 Trenton Rd. MD 21155 Upperco, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MD Veterans Cemetery 11-25 Garrison, Maryland 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. W 8728 Liberty Rd. Randallstown, MD 21133 23a. Pert/ Enter the disaese, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical Yneu moniA 3 days Examiner Dua to (or es a consequence of): Examiner Bowel obstruction The law requires that the death certificate be executed physician and the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequença of) attending pl signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sudden CANDIAC Arrythmins þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed s certificata has b 1 ☐ Yes 1 TYAS 2 No Hospital or Attending Physician: 25. Wes cese referred to medical examiner? Be 28. Place of Deeth (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetlent 3 DOA After this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 Netural death. Investigation 1 | Yes 2 | No 2 Accident after death 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 Homlcide 24 hours a 29a. Certifier 1. Certifying Physician: To the best of my knowledga, daath occurred et the time, dete end piece, end due to the cause(s) end menner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. To the I within 2 (Poque MD) 29c, License number 29b. Sign 29d. Dete signed (Month, Dey, Year)

use of deeth (Item 23e) (Type, Print)

Davidson-Randelle

32. Requitrar's Signature

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N. breen

DHMH 16 Rev 6/95

State

Registrar

Carried and the contract of the property of the contract of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death Month

1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physiclan** KLEIN blores NOVEMBER 23 (79) /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL KANDALLS TOUN BALTIMORE ONTONES 7 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1□M 2ॼF Director 215-24-8509 Dec 7, 1929 New York Usuel Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Randallstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 death with natural', or items 23a 10514 Marriottsville Rd. 21133 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Charles A. Klein & Son Elementary/Secondary (0-12) College (1-4or 5+) 12 years Bookkeeper Plumbing & Heating other t 17. Fether's Name (First, Middle, Lest) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linyry or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname, Be Frank F. Andes Sr. Yolanda Scioscia 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3190 Sharp Rd. Glenwood, MD Patricia A. Kennedy (Daughter) 21738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ₺ Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Family Cemetery 11-26 Randallstown, MD 21. Signetyre of Funeral Service Licensee 22. Name end Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Myocanoia MARCTION HOUR Examiner Due to (or as a consequenca of): CORONAM ANTEMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): INSULIN PERENDENT 68760 Physician/Medical 8 Due to (or es e consequence of) Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. o 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 141 ENTENSION Records, 24a. Was an autopsy performed? EMPHOUNT UASCULAR DISEASE Vital

Completed Be 2

Affair Attanding death. after death Director: To the Hospital within 24 hours To the Funeral completely filled

o

Division

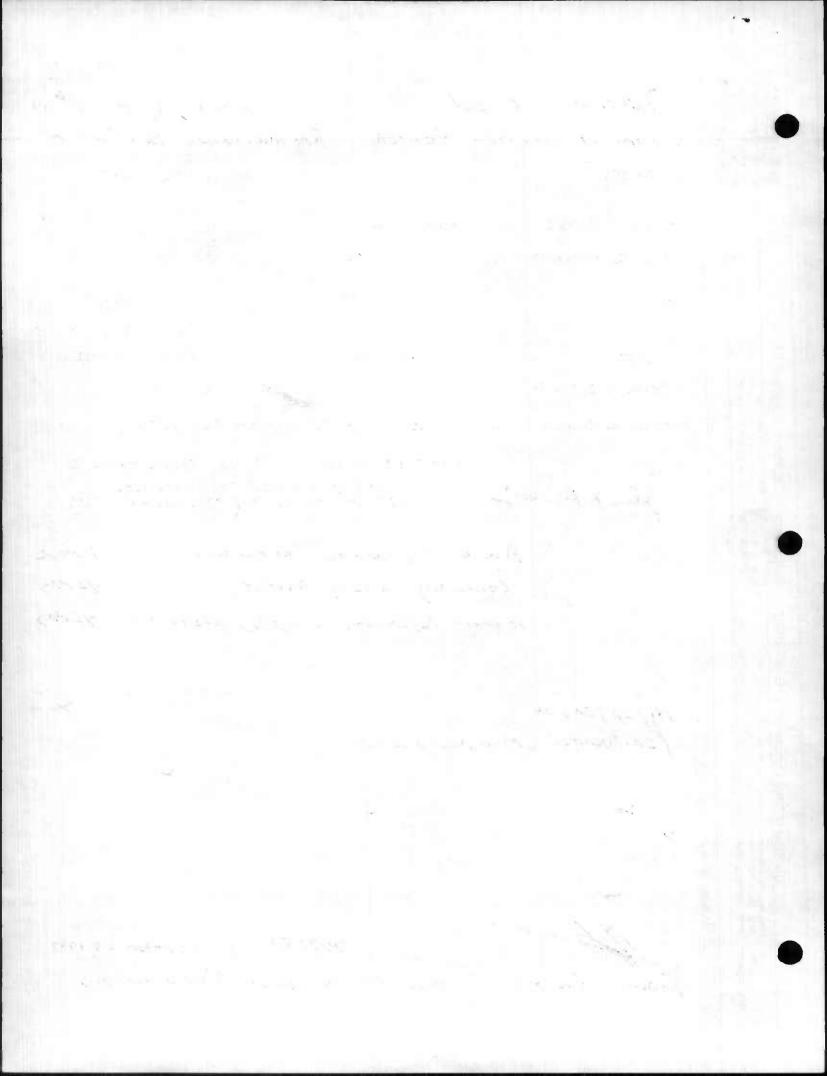
State Registrar

24b. Were eutopsy findings available prior to completion of ceuse of death? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) 2510 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ GOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Injury at Work? Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature end til all copilier 29c. License number 29d. Date signed (Month, Day, Year)

NOUSMBER 23 (99) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Hospin Center Romonestand MD

FINE. MD 1) ONTOWEST 337 Registrars Signature This New doon - Andell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 35573 Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth **Physician** 15 Am NOVEMBER /Medical 4e. Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GENESI CROMWELL NURSING CENTER BALTO COUNT BALTIMORE 5. Social Security Number If Under 1 Year Birthpiece (State or Foreign Country) 7. Age (In yrs. lest birthday) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) **Funeral** Hours 1□M 20F Director 212-01-0538 SEPT. 30, 1909 MARYLAND Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examiner inval be notified at Director 1 ☐ Yes 2 No MD. BALTIMORE TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 203 CHARMUIH RD. U.S.A. Funerai 21093 12. Wes Decedent Ever in U,S Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stelus 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes ② No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grede com 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementery/Secondery (0-12) College (1-4or 5+) IAW FIRM 12 YRS. 2 YRS. SECRETARY 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) 2 should be fi Be permit. Pages 1 and 2 should be Department of Haaith and Mental Important: If Itam 27 is marked or any Injury or other traumatic ev WILLIAM N. BITTRICK 2 GERTRUDE LANG 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DONALD KALKMAN 203 CHARMUIH RD. TIMONILM, MARYLAND 21093 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 XCremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 11/22/97 FEITSVILLE, MARYLAND 21. Signeture of Funeral Servica Licensee 22. Neme end Address of Fecility HRADLEY ASHION DABROWSKI MATTHEWS FUNERAL HOME, INC. whas BALTIMORE, MARYLAND 2134 WILLOW SPRING RD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth the mode of dying, such es cardiac or respiretory **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): 68760. 23 Physiclan/Medicai the Due to (or es e consequence of) certificate attending a Box 980 The law requires that the death P.O. Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobasco use contribute to the cause of death? the 5 1. Yes 2 No 3 Probably 4 Unknown signed l Records, à Be Completed 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes en autopsy performed? page 2 certificate 1 Yes 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical 26. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Attending After Division ours after dean 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 | No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a Voltan 24 hours a Completaly filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the ceuse(s) and menner mated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

of deeth (Item 23e) (Type, Print)

32 Registrar's Signeture

MID

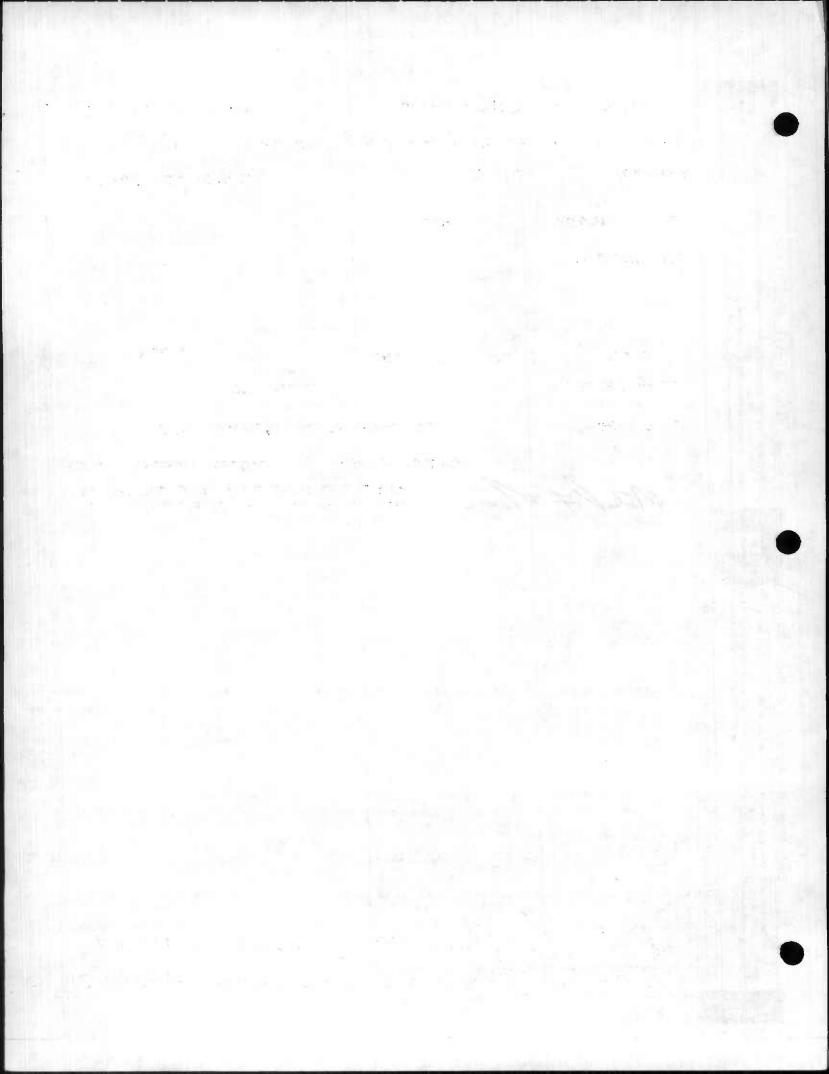
7151 HOLABIRD AVE, BALTO. MB. 21222

State Registrar 30. Neme and eddress of person who con

5 1997

FREDRIC 31. Dete filed (Month, Dey, Year)

VOV



.97-242	WI	ILIAM KRESS rt 1.27.28a-f per MEO	State of Mar	•	epartme Certifica			d Menta	, 0	07	355	71.	
Physic	ian	1. Decedent's Name (First, Middle, L	6-753 11/25/97 ast) Floyd Will:				Dout	2. Date	Reg. No of Oeath	1997 Ye		ime of Deeth :00 PM.	
/Med Exami		4a. Facility Name (If not institution, gi					4b. City, Town	or Location of	f Death 4c.	. County of D	eath		
Funeral Director				In yrs. last birth	rs. If Und	ier 1 Year s Days	If Under 24	Hrs. 8. Date Min. (Mor	8. Date of Birth 9. Birthplace (State or For				
ith the Maryland or 28a-f show	tor	10a. State 10b. County Delaware Kent	10	Oc. City, Town								lde City Limit	
death with the Maryland ime 23a or 28a-f show if must be notified at	al Director	10e. Street and Number 1125 Downs Chape	l Road			Zip Code 19938	3			Izen of Whet	Country?		
9 22	by Funeral	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: V			cedent of hoecify Cub	dispanic Origin an, Mexicen, P Specify:	? (Specify Yes uerto Rican, e	or No-	14. Race - A Black, W Specify:		an,	
	Completed	15. Decedent's E (Specify only highest gi Elementery/Secondary (0-12)	ducation ede completed) College (1-4or 5+)		Decedent's Us 'Give kind of w life. DO NOT Sbesto	vork done use retire	during most of d)	working		16b. Kind of Business/Industry Asbestos			
Baltimore, Maryland 212- permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: if Item 27 is merked other than any Injury or other fraumatic event, if a Me pince.	To Be	17. Father's Name (First, Middle, Les Floyd D.	Kress					Rutl	Middle, Meiden h Frye				
e, Mar and 2 sh tealth and m 27 is m		19a. Informent's Name/Relationship Sharon L. Kress	- Wife	P	.O. Bo	x 410	O, Ches	wold, 1	DE 199	ber, City or Town, State, Zip Code) 19936			
Baltimore, permit. Peges 1 ar Department of Hea Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 Burial 2 MiCremation 3 4 Donation 5 Other (Special Control of the	JAMINOVALITORI SIALE	20b. Place of I cemetery Capito	cremetory or			11-19 1997	-19				
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Is, P.O. Box as that the death cert igned by the attendinbe deteched for use	by Physician/Me	Part II. Other significant conditions	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause 1 Vas 2 No 3 Probably		
Records le law requires has been sig	Completed b							248	. Was an autor performed?		available completic of death?	opsy findings prior to on of cause	
f Vital Rysician: The I	To Be Co	25. Was cese referred to medical examiner? 1 ☑ Yes 2 □ No	Hospital: 1 ☐ Inpatient	2□ ER/Outp	patient 3 C	Oth	AP.	Death (Check	/	□ No	1 Ves	2 No	
ivision or r Attending Ph tar death. Irector: Affer thi	Certification:	27. Menner of Death 1 Natural 2 Accident 3(X) Suicide 4 Homlcide 5 Pending Investigation 6 Could not be determined	28a. Date of Injury (Month, Day Ye	28b. Tir lnj 97 found At home, fam Specify)	me of A ury A 9:15 ^M	28c, Injur Wor 1 🗆		28d. Des subject 28f. Loca City	ct shot sation (Street en or Town, Stete	elf od Number or	Rural Route	Number,	
To the Hospital of within 24 hours of To the Funaral Di completely filled is	edical	29a. Certifier (Check only one) 1 Certifying Pi 2 Medical Exam	nyaician: To the best of m miner: On the basis of exe and manner steted	emination and/	death occurred or Investigation	d at the tir	ne, date and pl plnion, death o	ace, end due t ccurred at the	to the ceuse(s) time, dete and	end manner I plece, and o	es steted. due to the ce	use(s)	
To the within 2 To the complex	M	30. Name end address of person who	iore M	29d. Date signed (Month, Dey, Year) NOV. 16, 1997									
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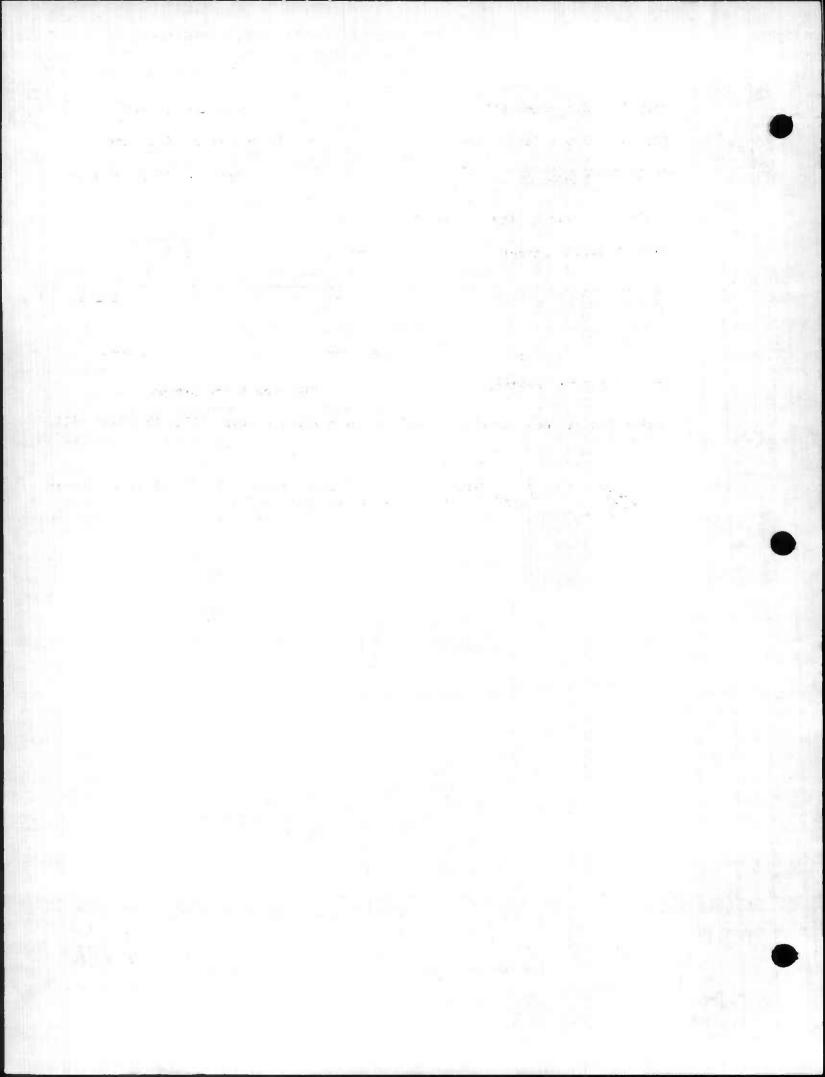
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				tificate of			ig. No.	355/5	
п	Physic	ian	1. Decedent's Name (First, Middle, Last)			2. Date of Death	h Dey Ye	3. Time of Death	
	/Medi		Mary Page Jones Kendall		1	lovember	1, 199		
	Examir		4e. Facility Name (If not institution, give street end number)		4b. City, Town, or Lo	cation of Deeth	4c. County of D		
			5501 West Forest Park Avenue		Baltimore	County	Baltime	ore	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 75 Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Oct. 11	Birthplace (State or Foreign Country) Virginia		
	pue *		Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Loc	etion				10d. Inside City Limits	
	e Meryle	ctor	Maryland Baltimore City Baltimore					12€ Yes 2 No	
	23a or 26	al Dire	10e. Street and Number 2513 Christian Street	10f. Zlp Code 21223			U.S.A.	t Country?	
020	al', or items	by	1 Never Married 2 Married 1 Yes 2 No	/as Decedent of H Yes, specify Cub ☐ Yes 2 1 No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Bleck, White, etc. Specify: White		
21215-0020	se that the death certificate be assecuted grand be filled before the death certificate be assecuted by the attending physician and before the attending physician and before the properties of the standing physician and be detached for use as the buriel-transit any injury or other traumatic event, any physician/Medical Examiner To Be Company and the standing physician and the physician a	(Specify only highest grade completed) (Give kife. D. College (1-4or 5+)	O NOT use retire	during most of work!	ing	16b. Kind of Business/industry			
		12 5+ Ho 17. Father's Name (First, Middle, Last)	memaker	40.04-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-	(F)	Own Ho	ome		
and	of its by	hes been signed by the attending physician and beginning to the standard beginning to the standard beginning to the standard standard the standard	Charles Burton Kendall, Sr.		16. Mother's Name		The same of the sa		
3	or Attending Physician: The lew requires that the death certificate be associated after death. The control of			Florence					
Maryland				and Number or Rura					
	E = 8 L		9		Road, Owi				
Baltimore,	Peges nent of unt: If it ury or o		20a. Method of Disposition 1 □ Burlal 2 □ Cremation 3 □ Removal from Stete 4 ☑ Donetion 5 □ Other (Specify) 20b. Place of Disposition cemetery, crem.	atory or other pla	ce)	Date 2	20c. Location - City	or Town, State	
Bali	Departition of the control of the co			ltimore.	Maryland	21201		Approximate Intervel Between	
Box 68760,	Medical Examined be snecroted by by sicten and street bring-transit as the buriel-transit	an/Medical	Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest a. Due to (or as a consequence of the conditions) by the conditions of the con	ence of:	ray K Bulos Farlin	yreste bhlele	ensem its	Onset and Death 2 years 6 month	
	the a	/sic	Part II. Other algnificant conditions contributing to death but not resulting in the unc	derlying cause giv	ven in Part I.	23b. Did to	bacco use contrib	outs to the cause of death?	
s, P.O.	and by detacl		o besity			1 🗆 Ye	2510 3	Probably 4 Unknown	
of Vital Records,	¥ 00 00 00 00 00 00 00 00 00 00 00 00 00					24a, Was ar perform		4b. Were autopsy findings available prior to completion of cause of death?	
H	The ate h	Son				1 □ Ye	s ZUNo	1 ☐ Yes 2 ☐ No	
/ita	lan: ortific ctor,		25. Was case referred to medical examiner?		26. Piace of Death	(Check only on	of		
2	0 0		1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3□ DOA Oth	ner: 4 Nursing Ho	me 3 Reside	nca 6 Other (5	Specify)	
Division o	After fune		27. Manner of Death 1 Natural 5 Pending (Month, Dey Year) 2 Accident 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury	28c. Injur Wor M 1	yat rk? Yes 2 □ No	28d. Describe ho	w Injury occurred		
Divis	rs after de al Directo ed in by t	Certific	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, fectory, office		28f. Location (Str City or Town	reet and Number o , Stete)	r Rural Route Number,	
	Ne Hospital	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the control on the desired examination and/or investigation of the control o	occurred at the tirestigation, in my o	me, dete and place, a opinion, death occurre	and due to the ca ed at the time, de	use(s) and menne ete and piece, and	r as stated. due to the cause(s)	
	within 2 To the comple	M	29b. Signature and title of certifier	29c. Licens	se number	29	d. Date signed (M	lonth, Day, Year)	
			Kain S. Kanfinen M. 1	De	96307		17 /0/	97	
			30. Name and address of person who completed dause of death (Item 23a) (Type, PRAN) S. KARIPINEN 4000 ANNAP	rint) 0215 R	D BAL	TIMOR	E ND	2)227	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 5 1997 January Manual Strain Signature Author Manual Strain Strain Signature Author Manual Strain Strain Signature Author Manual Strain S				1 110	No.	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Deta of Death 1. Decedant's Neme (First, Middla, Last) Year James Lindley Larduskey, Jr. November 21 1997 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Union Memorial Hospital Baltimore City Worths Days Hours Min. 8. Data of Birth (Month, Dey, Yaar) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplaca (Stata or Foreign Country) M 2DF Days Yrs. Nov. 21, 219-01-3937 1918 Baltimore City 79 Usual Residence of Dacedani 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 636 Colorado Ave. 21210 USA 12. Was Dacadant Ever In U.S. Armed Forcas? 1X□ Yes 2□No Air If Yes, Give Force Year or Dates: 1940-1978 11. Maritai Stalus Was Dacadent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Nevar Marriad 2 Married 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education 16a. Dacedani's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 18b. Kind of Business/Industry (Specify only highest greda complated) Elamentery/Secondery (0-12) Collega (1-4or 5+) 12 Purchasing Agent Utilities 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) James Lindley Larduskey, Sr. Lillian Grace Wilker 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Code) Ruth L. Larduskey - Wife 636 Colorado Ave., Balitmore, MD 21210 20b. Placa of Disposition (Nama of cametery, cramatory or other piece) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramovai from State Nov.25,1997 4 ☐ Donationy 5 ☐ Othar (Specify) Woodlawn Cemetery Baltimore, MD unetal Service Licensee 22. Nama and Addrass of Facility Lemmon Funeral Home ston VCLengrand, Jr10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarvel Betw Onsel end Death Immediata Causa (Final CORONARY disaase or condition rasulting in deeth) Due to (or as a consequanca of): ARDIDMYOPATHY Saquantially list conditions, if any, leading to Immadiata causa. Enter Underlying Ceusa (Disaasa or Injury Dua to (or as a consequenca of) ACUTE ON CHRONIC RENAL FAILURE that initiated evants rasulting in death) Last Due to (or es a consaquence of). Part il. Other algnificent conditions contributing to daath but not rasulting in the undarlying causa givan in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Wera autopsy findings eveilebla prior to complation of cause of deeth? 24a. Was an autopsy performed? 1 Yas 2 □ No 1 ☐ Yas 2 No 25. Was casa refarred to medical 26. Place of Death (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

the Medical Examiner

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Department in important: If any injury or

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Pages 1 and 2 should be

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altimore, Maryland

Director

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Physician/Medical ģ Completed Be 2

Certification:

Director: of a edical Tothe

to

Division

State Registrar

Certifying Physicien: To tha best of my knowledga, daath occurred at tha tima, data and place, end dua to tha causa(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and place, and dua to the causa(s) and manner stated. 29b. Signatura end titla of cartifiar

29c. Licansa number

28c. Injury at Work?

29d. Dale signed (Month, Dey, Year)

28f. Location (Streat and Number or Rural Routa Number, City or Town, State)

Othar: 4 Nursing Homa 5 Residenca 6 Othar (Specify)

28d. Dascribe how Injury occurred

AU4176435K9260

1 ☐ Yas 2 ☐ No

November 21, 1997

and addrass of person who completed causa of death (Item 23e) (Type, Print)

Erika N. Kane, MD 201 E. University Parkway Balto, MD 21218

28a. Dete of Injury (Month, Day Year)

31. Data filed (Month, Day, Year) NOV

5 Pending Invastigation

6 ☐ Could not be datarmined

1 ☐ Yas 2 No

27. Menner of Daath

1 Natural

2 Accident

3 Suicida

29a. Certifian (Check only onel

4 Homicida

2 5 1997

32. Ragistrar's Signature Julia Davidson-Randall

1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At homa, farm, straal, fectory, offica building, atc. (Specify)

Land to the territory of the second Ballating the same and the second of the same and the sam

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Deeth NovEMBER 22Nd Year 09-51 **Physician** VANCY. ANN /Medical 4b. City, Town, or Location of Death 4e. Feclity Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** HOSPITAL BACTIMORE MORTHWEST BALTIMBRE if Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Deys 5. Sociel Security Number Birthpiece (State or Foreign Country) **Funeral** 1 M 2 F Jan 25 1965 029-60-1308 32 Yrs. Director Mass Usuei Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at Md Ba Ito DWINGE 1 ☐ Yes 2 ☐No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? LODGE CT. UNIT3 21117 4ZU Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 11. Meritel Stetus Pages 1 and 2 should be filed within 72 hours effer nent of Heelth and Mental Hygiene. 1 Yes 2 No if Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed other than "natur 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retinfol) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) Provider Collage (1-4or 5+) DAY Care Home 12+1 192 17. Father'e Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be John Waskiewicz marked Elsie GRABIEC 19a. informent'a Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 17 Rodney Lee- Husband 3 DEER LODGE CT. Unit 3 Owing EMills. Hd 27 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) EUFRGREEN CEMETERY # Funerei Sarvice Licenses 22. Name and Address of Facility 51215 4300 Wabash Aug. 23a. Part. Enter the theese, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or raspiratory arrest shock, or heart that are. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** immediete Cause (Finei disease or condition resulting in death) /Medical SEPTIC SHOCK Examiner Due to (or es a consaguença of): Physician/Medical Examiner PNEUMONIA requires that the death certificate be executed physician and the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in deeth) Last Dua to (or as a consequençe of): Box 68760. HODGKINS DUSEASE Due to (or es a consequence of) signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? page 2 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: efter death. Director: After this certific 25. Wes casa raterred to medical exeminer? 26. Piece of Death (Check only one) Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1□ Yes 2 No 28a. Dete of injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred 1/Neturei 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 28a. Piece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours of To the Füneral D Certifying Physician: To the best of my knowledge, deeth occurred et tha time, deta end piece, end due to the causa(s) and manner es atlated.

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| Certifying Physician: To the best of my knowledge, deeth occurred et tha time, deta end piece, end due to the causa(s) and manner es atlated. 29e. Cartifier (Check only one)

State Registrar

31. Dete filed (Month, Dey, Year)

29b. Signeture and title obcertifier



asanthaleumar

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

M. VASANTHAKUMAR MD, 821. N. EUTAW ST. # 407, MD21201.

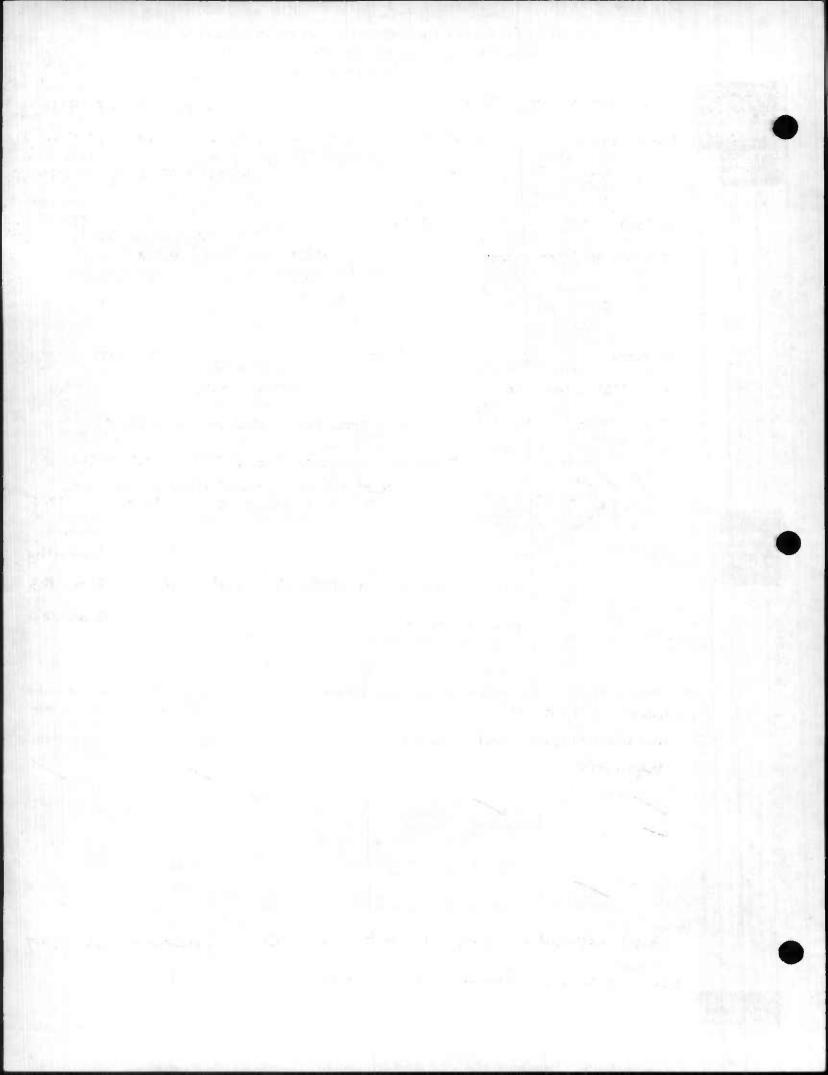
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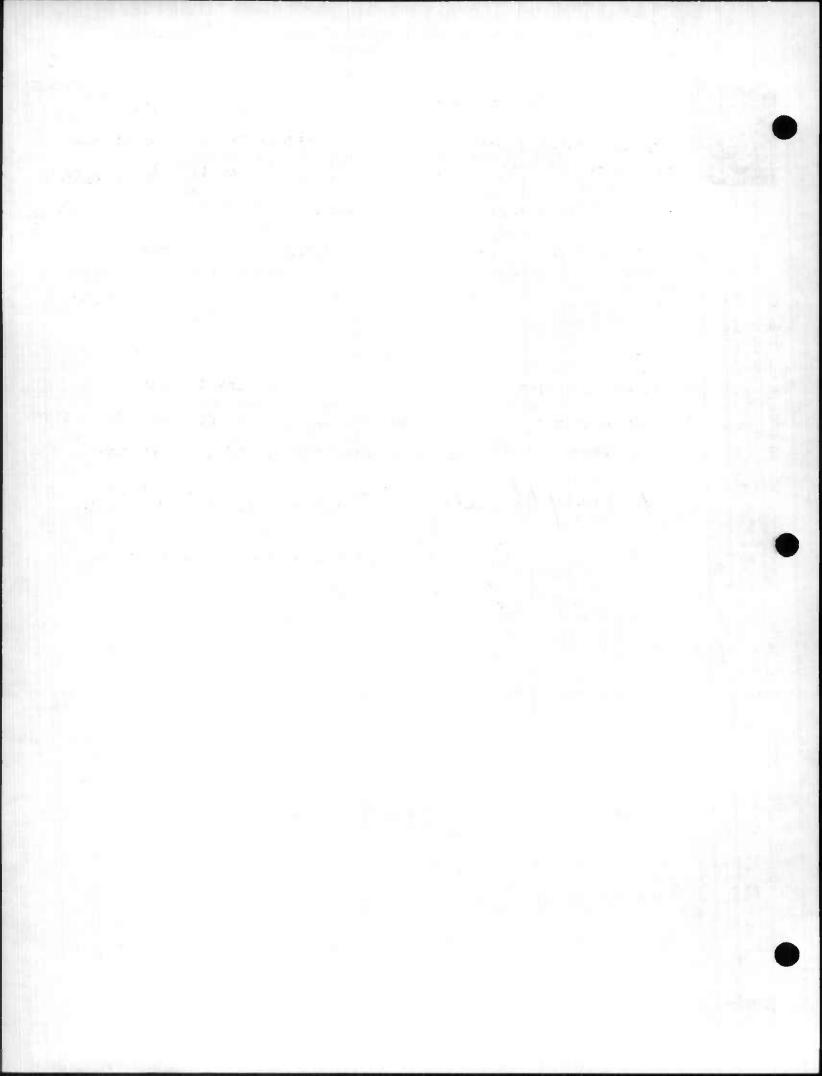
State of Maryland / Department of Health and Mental Hygiene Q 7 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Month **Physician** LEHNHOFF LILLIAN 11:05pm NOV. 22,1 1997 /Medical 4a. Fecility Nema (If not institution, give street and number) 4b City Town or Location of Deeth 4c. County of Death Examiner River Baltimore Ivy Hall Nursing Center Middle 5. Social Security Number if Undar 1 Yaar | If Undar 24 Hrs. 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** (Month, Day, Year) April3,1912 1 M 2 S F Months Days 212-14-9598 Yrs. Director 85 Maryland Usuel Rasidance of Decedant the Marylend 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show Dunda1k Md. Baltimore 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? death with 6 21222 USA 1605 Evergreen Drive Items 23a Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, Whita, atc. 11. Maritel Status filed within 72 hours efter 1 Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yas 2 ☐ No Specify: þ Specify: White 3 □ Vidowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) Bakery 8th Clerk 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Peges 1 and 2 should be end Mental Gertrude J. Nist James B. Arrick 2 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) - 60 permit. Peges 1 and 2: Department of Health er Important: If Item 27 is any Injury or other tra 1605 Evergreen Drive Baltimore Md. 21222 Frank Lehnhoff Jr./son 20b. Placa of Disposition (Name of cematary, cramatory or other placa)
Metro Crematory Inc. 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 11/24/97 Baltimore Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensas 22. Nama and Addrass of Facility Connelly Funeral Home of Essex er plications that caused tha could one cause on each line. 300 Mace Ave. Baltimre Md. 21221 ar tha moda of dying, such as cardiac or raspiratory arrast, Appl 23a. Part1. Entar tha diseese, or compi shock, or haart failura. List only or Do not antai **Physician** /Medical immediata Causa (Final disaasa or condition rasulting in death) Examiner Physician/Medical Examiner 408/1 'a The lew requires that the death certificete be executed burial-transi Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consaquanca of): Box 68760. that initiated evants rasulting in daath) Last the Dua to (or as a consequence of) USB BS 1 P P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by the detact 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings aveilebla prior to complation of cause of death? page 2 should Completed 24a. Was an autopsy performed? certificate hes 1 Yas 2 1 NO 1 Yas 2 No Division of Vital Hospital or Attending Physician:
24 hours effer deeth.

Funeral Director: After this certified letely filled in by the funeral director; in the function of the funct Be 25. Was case rafarred to medical 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 28c. Injury at Work? 27. Mannar of Death Data of injury (Month, Day Year) Certification: 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Naturai 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 - Homleida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical (Check only within 2 To the F 29b. Signature and titla of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of death (itam 23a) (Type, Print) BLO BALT 223 6 7 Rowi Mp 2/22/

32, Registrar's Signature

State Registrar



CORNELIA MUREL

Physician

/Medical

Examiner

1. Decedent's Na

4a. Facility Neme (If

2906 EDG

10h County

Please Type or Print in Black Indelible State of Maryland / Department		•	ene _	
Certificate	e of Death	Re	g. No. 9 /	35580
(First, Middle, Lest) Ornelia C. Mc	irel	2. Date of Death Month NOV • 1	Day Year 9, 1997	3. Time of Death
not institution, give street and number) ECOMBE CIRCLE SOUTH	4b. City, Town, BALTI	or Location of Death	4c. County of Deat	
3674 6 Sex 1 M 20 F 7. Age (In you last birthday) If Under Months	1 Year If Under 24 F Days Hours M	frs. 6. Dete of Birth (Month, Day	9. Birt	hplace (State or Forei

Foreign

10d. Inside City Limits

1 Yes 2 No

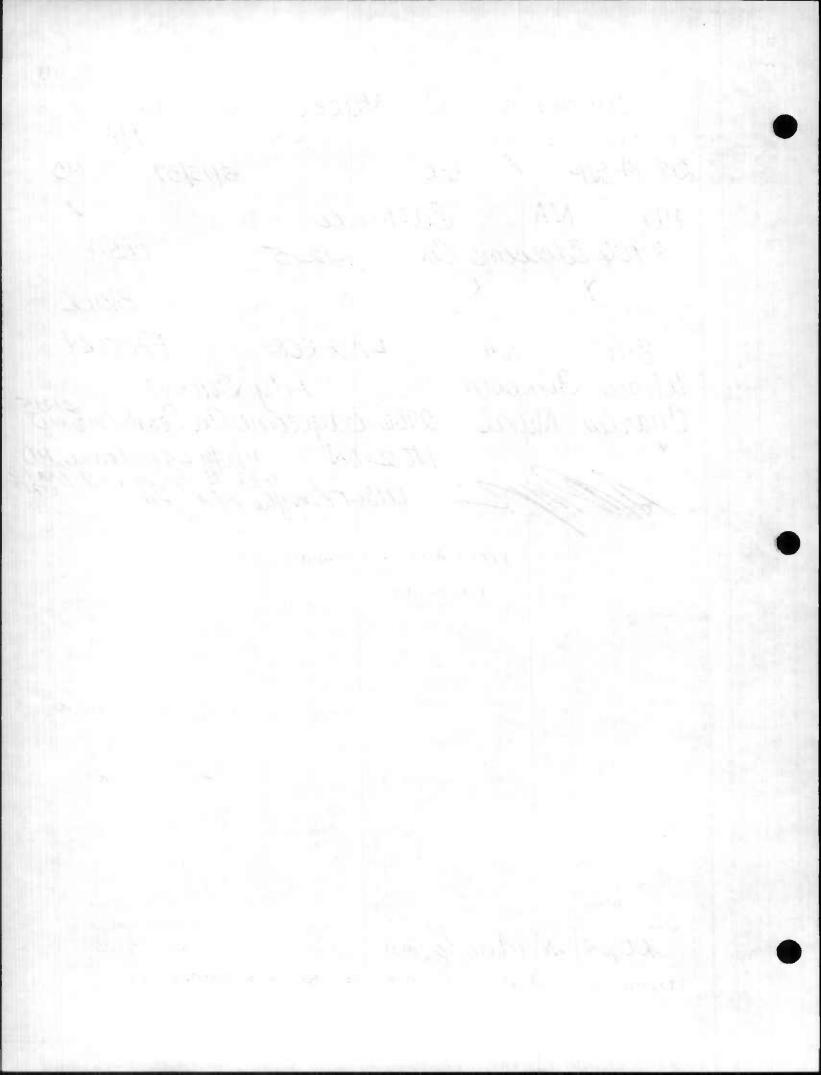
Funeral Director

with the Maryland 28a-f show must be nothing at or items 23a or filed within 72 hours after death event, the Modical Examiner other than

Funeral Director 10g. Citizen of What Country' 1 Never Married 1 ☐ Yes 2 No Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 20b. Place Burial 2 Cremation 4 Donation 5 Other (Specify) Immediate Cause (Finel Tamponade disease or condition resulting In death) Endocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed? 1. Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) XX Yes 2 No 1 Inpatient 2 ER/Outpatlenf 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Baltimore, Maryland 21215-0020 Pages 1 and 2 should be Important: If item 27 is marked any injury or other traumatic ev 10 Approximate Interval Between Onset and Death Physician /Medicai Examiner Completed by Physician/Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? After this certificate has 1 Yes 2□ No Be Other: 4 Nursing Home 5XX esidence 6 Other (Specify) Medical Certification: To 28d. Describe how Injury occurred Attending within 24 hours after deat To the Funeral Director. 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

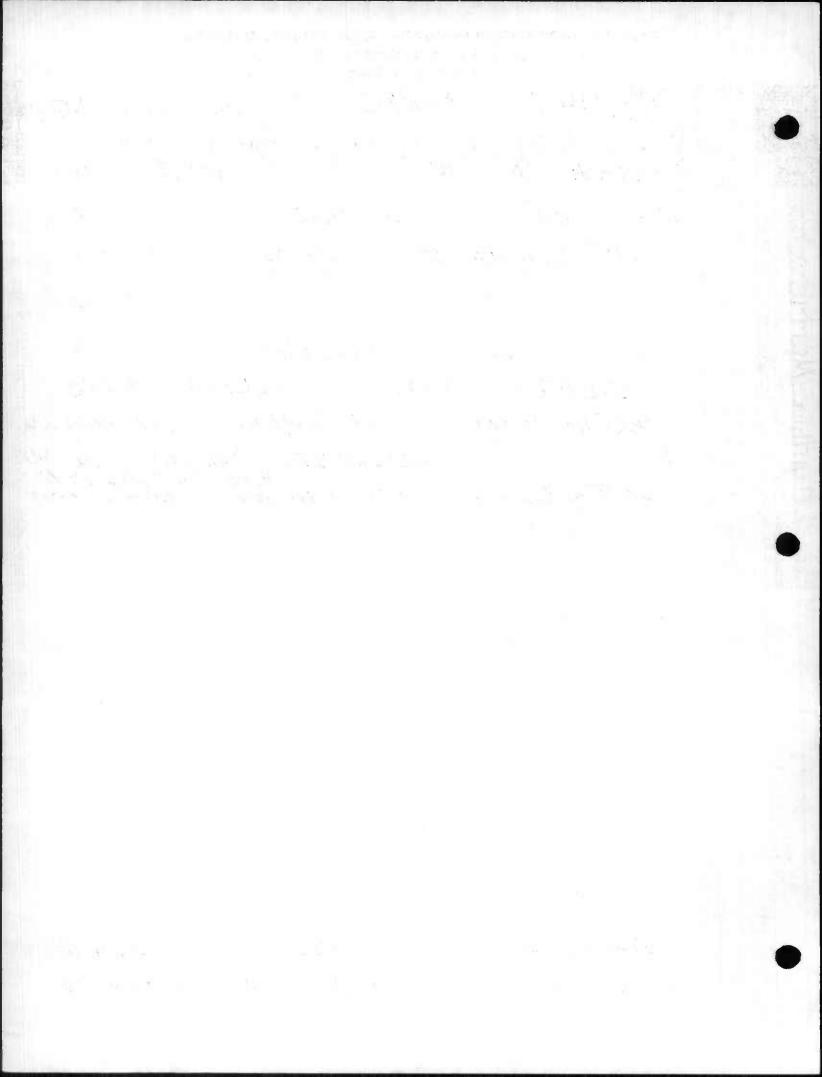
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E 20, 1997 NOV. 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Strphen S. Radentz 31. Date filed (Month, Day, Year) 32. Ref 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature Pandell NOV 2 5 1997 Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death

				Otato of Marylar	Certific				Reg. No.	1 35	581
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	AEN	MORRIS	5		2. Data of Do Month	Day	797 4	ne of Death
F	Examin uneral		47-51-1001	haef New	Sing Ce . lasybirthday) If Un Month	enter ndar 1 Yas hs Day		more	nth /	9. Birthplace (St	ata or Foreign
Marylend	28a-f show	tor	Usual Rasidance of Dacadant 10a. Stata 10b. County	10c. C	ity, Town or Location	TIN	IOLE		,	11.1	de City Limits Yas 2□No
death with the Marylend	23a or 28a-fi	al Director	10e. Street and Number 2915 B	righton		Zip Code			10g. Citizan of V	What Country?	
	or flems	by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar In U Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Dates:	If Yas, s	specify Co	f Hispanic Origin? (S uban, Maxican, Puart to Specify:	pecify Yas or No o Rican, atc.)	14. Raci Blaci Specify	e - Amarican India k, Whita, atc.	n,
MONTON d 21215-0020 filled within 72 hours after Hygiena.	r than "natural", the Medical Exc	Completed	15. Decedant's Educ (Specify only highast grade Elementery/Secondery (0-12)	cation a complated) College (1,4or 5+)	16a. Decedant's U (Giva kind of life. DO NO	sual Occ work don T usa rati	cupation na during most of wor ired)	king	16b. Kind of Bu	FFIC	5
Maryland 2 d 2 should be filed th and Mentel Hygi	D >	To Be C	17. Fathar's Nama (First, Middla, Last) STEPT	EN M	OKRIS		18. Mothar's Nan	na (First, Middle ERTH	, Maidan Sumam	MORRI	15
5 6	27 r tr		19a. Informant's Name/Ralationship (Type BERTHA	MOKRIS	291	14	Bugh	ton i	ST. BALL	7. MO	21216
The same of the same of	ortant: If its injury or o b.		20a. Mathod of Disposition 1 W Burlai 2 Cramation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	amoval from Stata	Place of Disposition (I comatery, cramatory of LESTE 22. Nama	CKN	STAR drass of Facility	11/25/71 125/71	Cati	City or Town, State	MO
Bailt.	any		23s. Part1. Enter the disease, or complishook, or heart failure. List one or	millions thet causad tha daa	th. Do not enter the n	moda of d	Ming, such es cardiec	10 C 5	T BAL	N. MP.	2/2/7
/Me Exa	sician edicai miner	her	Immediata Causa (Final disaasa or condition rasulting in daath) a	TERMINAL] RUPU				Onsat	Between and Deeth
68760, ifficate be executed	sician and buriel-transit	al Examiner	Saquentially list conditions, if any, leading to Immadiata cause. Entar Undarfying Causa (Disaasa or Injury	Due to (or as a consequance	of):					
687	g phy as the	in/Medical	that Initiated avants rasulting in death) Last		or as a consequance of	of):					
P.O. B	ed by the etter	Physician/N	Part II. Other significant conditions con	tributing to death but not ras	sulting in the underlyin	ng causa	givan in Part I.			atributa to the car	
ords	been signer	Completed by							an autopsy ormad?	24b. Wara auto available p complation of daath?	rior to
			OF Was seen referred to reading						Yas 2 No	1 Tas	2 No
of Vita	this raidi	To B	25. Was casa referred to medical axaminar? 1 Yas 2 No H	28a. Date of Injury	28b. Tima of	DOA 28c. In		oma 5□ Ras	ona) Idance 6 ⊡Othi how Injury occurr		
Division or Allending	al Director: After ad In by the funer	Medical Certification:	1 Natural 2 Accidant 3 Suicida 4 Homicida 5 Panding invastigation 6 Could not be determined	(Month, Day Year) 28a. Place of Injury - At h building, atc. (Speci	Injury M oma, farm, street, fac	1	☐ Yas 2☐ No		(Straat and Numb wn, Stata)	er or Rural Routa	Number,
H South	Furnera tely file	dicai Ce	29a. Certifiar (Check only one) 1 Cartifying Phys	Iclan: To the best of my kno ar: On the basis of axamina and mannar stated.	owledga, daath occurration and/or Invastigat	red at the	time, date and place y opinion, daath occu	, and dua to tha rred at tha tima,	cause(s) and ma data and place, a	nnar as stated. and dua to tha cau	1 80 (S)
To the	To the Fun completely	Me	29b. Signatura and titla of certifiar				insa number			d (Month, Day, Ye	
			30. Nama and addrass of parson who con	moleted cause of death fitter	n 23a) (Type, Print) 7206 Pavi	H4:	5431		Novemb	ver 24, 1	カナ
Y	Stat Registra	te	$\Delta = 0$	32. Registrar's Sign	7200 Pari		leights A	venue	Balt	more. M	D

DHMH 16 Rev 6/95



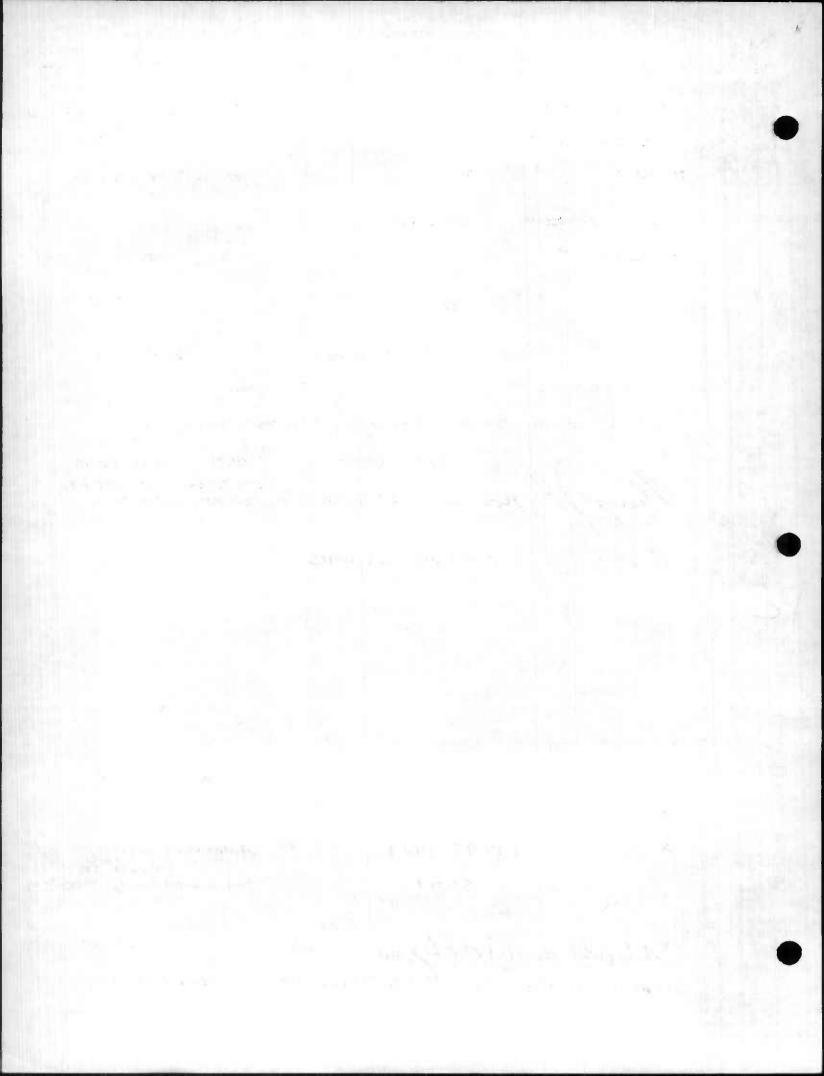
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State of Maryland / Department of Health and Mental Hygiene 97 35582

ı	Director
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filled within 72 hours effer deeth with the Maryland Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other treumstic event, the Medical Examinar Trust be notified at ORCE.
	Dhooleise
	Physician /Medical Examiner
Division of Vital Records, P.O. Box 68760	if or Attending Physicien: The law requires that the death certificate be executed as the death. I Director: After this certificate has been signed by the ettending physician and in by the funeral director, page 2 should be deteched for use as the burlet-transit

LINDA L.	. 1	MROCKOWSKI			,		Cer	tificat	e of	Death		Reg. No.	1 0	3382	
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		4a. Facility Nama (If not institution	n, give	streat and n	um <i>ber)</i>					4b. City, Town, or				1510 111	
		ANNE ARUNDEL	HOS	PITAL	CENTE	ER				ANNAPO	LIS	ANN	E ARUI	NDEL	
Funeral Director		5. Social Sacurity Number 214461709	6. Se	х □м 2√ Д F	7. Aga (Ir.	yrs. last b	irthday) Yrs.	If Undar Months	1 Yea Days		. (Month, Di	rth ay, <i>Year)</i> r 17,1944	9. Birthple Counti	ace (Stata or Foreign ry) land	
and w		Usual Rasidanca of Dacadant 10a. State 10b. County	,		10	c. City, Toy	vn or Loc	cation					10	d. Insida City Limits	
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r dee	Jue	11. Marital Status		12. Was Dec Armed F	cadant Ever	r In U,S.	13. V	Vas Daced	dant of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No)- 14. Rac	ca - America ck, Whita, a		
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Ment Ment arked	10	David Smith								Opal L	eeson				
2 should and Men Is marke reumatic		19a. Informant's Name/Relations	ship (T)	rpe, Print)		19	b. Mailin	g Address	(Stree	et and Number or R	u <i>ral Routa N</i> um <i>t</i>	er, City or Town,	Stata, Zip (Coda)	
end eeith n 27		Joseph R. Mroc	kows	ki / H						Riviera Be	ach, Mary	Land 21122	2		
of He		20a. Method of Disposition 1 Burial 2 □ Cramation	2 🗆	am aval fuam	2 Ctoto	Ob. Place of cemeta	of Dispos	sition (Nan	na of thar pl	ace)	Data	20c. Location	- City or Tow	m, State	
Peges nent of I int: If Ite		4 □ Donation 5 □ Other (S			State	Holy (11/24/97	Baltimor	e. Mar	vland	
permit. Departrimonts any inju		21. Signature of Funeral Seylice	Lighns	4			22.	. Name an	d Addı	ress of Encility					
8858		Menny	DS	4mm	-0		1	001 pi	tah:	ie Highway,	orge J. Go				
		23s. Parts. Enter the disease, or shock, or heart failure. List	compl	ications that	ceused tha	daath. Do	not ante	or the mod	e of dy	ring. such as cardia	c or respiratory a	rrest.		O Approximate	
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/Medical		Immadiata Causa (Final											- 1		
Examiner		diseasa or condition rasulting In daath)		э	Mul				un	ies					
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shysic this c	2	1√x Yas 2 No	- 1	lospital:	Inpatiant	XX ER/O	utpatient	3□ DC	A	ther: 4 Nursing H	lome 5 ☐ Resi	dance 6 □Oth	rar (Specify)		
h. After t	:uo	27. Mannar of Death 1 ☐ Natural 5 ☐ Pandir	na	28a. Data (Mor	of Injury oth, Day Yes	ar) 28b.	Tima of Injury	2	8c. Inju	ury et ork?	28d. Dascribe	how injury occur	red		
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or Attendent effector:	Ě	3 Suicida 6 Could 4 Homicide determ		28e. Plac	e of Injury - ling, atc. (S)	At homa, fa	arm, stra	at, factory	, office		28f. Location (Streat and Numb	per or Rural	Routa Number,	
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10		30. Nama and addrass of parson Stephen S.		2ade	Sti	111	Penr	n Str	eet	, Baltimo	ore, Mar	yland 2	1201		
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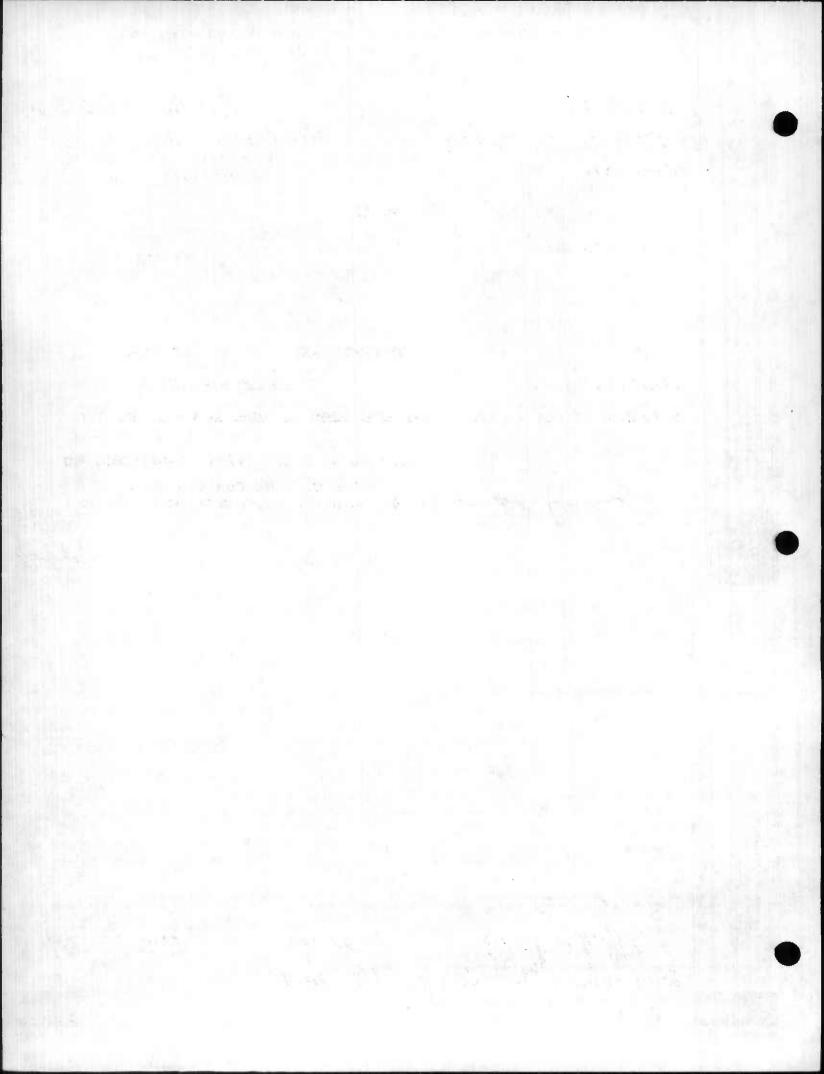


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle 2. Date of Death **Physician** oseph 0 /Medical City, Town or Location of Death RUME et and number) **Examiner** Glen Hospita 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (Steta or Foreign Country) Funeral 1 XM 2□ F Months Days Hours 212-96-2177 33 Yrs. Director 9/9/1964 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumetic event, the Mindical Examiner must be notified at MD ANNE ARUNDEL GLEN BURNIE 1 Yes 2 No Director 10e. Street and Number 1005 KELSO DRIVE 10f. Zip Code 21061 10g. Citizen of What Country? U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: Specify: WHITE à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementery/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 12 DRYWALL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be permit. Pages 1 end 2 should be 1 Depertment of Heelth and Mental I Important: If Item 27 is marked of any injury or other traumatic eve MELVIN E. MILLER LORRAINE BIERNAT 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) KATHLEEN MILLER - WIFE 443 SHORE ACRES RD., APT. 3A ARNOLD, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STANISLAUS CEM. 11/24 BALTIMORE, MD 21. Signature of Fyorrel Service Lie 22. Name and Address of Facility
RAYMOND C. FINK FUNERAL HOME 426 CRAIN HWY., S.W. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. Limit only one ceuse on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finai disease or condition resulting in death) Examiner Examiner be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical the Due to (or as a consequence of): 188 BS Pol P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, by 24b. Wera autopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en autopsy partormad? peen page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was gase referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this After thi 27. Menner of Deeth Date of tnjury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how Injury occurred Attending 1 Najerel 5 Pending investigation f-inflicted 1997 death. To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu quishot wound 2 Kccident Plece of Injury - At home, fagm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 M Suicide (Street and Number or Rural Route Number, 4 Homicide nome 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only 29b. Signatur 29d. Date signed (Month, Dey, Year)

State Registrar 31. Date filed (Month, day, Year) Reporture Signature NOV 2, 5, 1997

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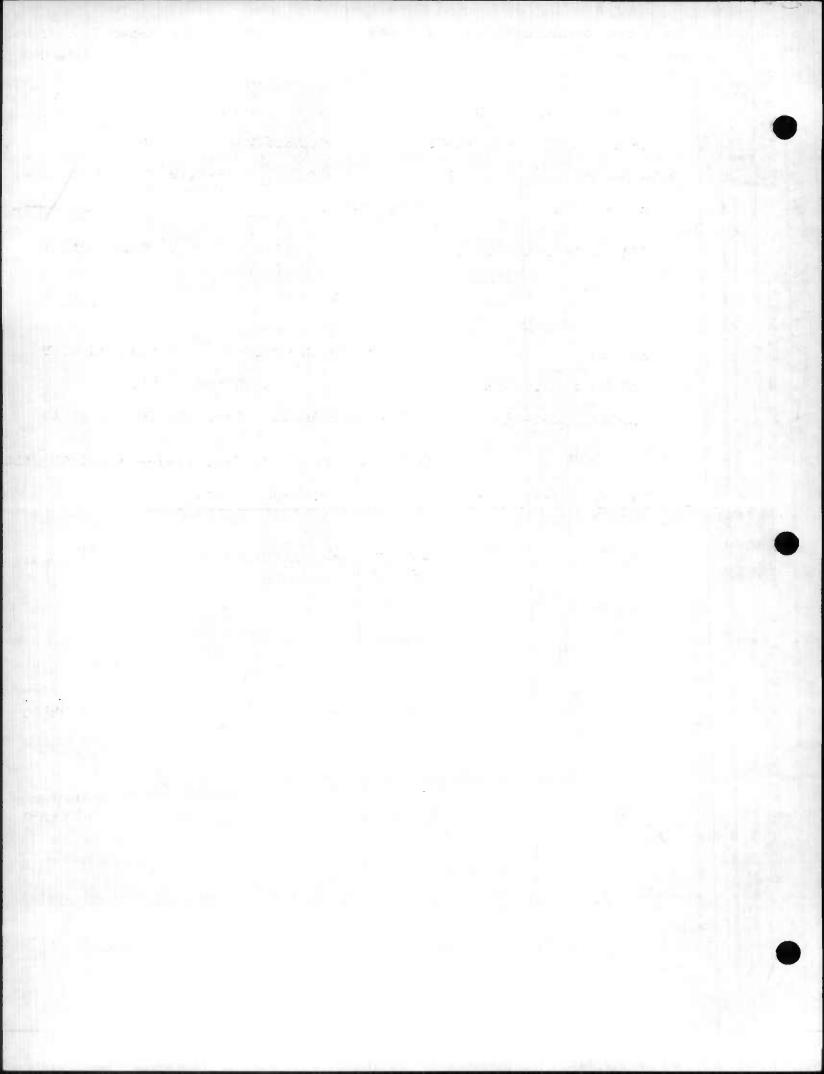


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** NOVEMBER 21 1997 Am LAWRENCE W. /Medical 4e. Fecliity Neme (If not institution, give street end number) 4b City Town or Location of Deeth 4c. County of Death Examiner BALTIMORE STELLA MARIS AT MERCY if Under 1 Year if Under 24 Hrs. 9. Birthplace (Stete or Foreign Country)
BALTIMORE, 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1 3M 2□ F **Director** 217-20-0615 SEPT.18,27 Usual Residence of Decedent 10b. County NA 10c. City, Town or Location BALTIMORE 10e. Stete 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Madical Examiner must be notified at MD XXYes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? STATES 21215 UNITED 3811 CEDARDALE ROAD Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married XX Married XI XI Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2X No Specify: P Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry tal Hygiana. Elementery/Secondery (0-12) College (1-4or 5+) CORRECTIONAL OFFICER BALTIMORE CITY 12 th 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) h end Mental h ELIZABETH BATTLE LAWRENCE K. MOSS To 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pages 1 and 2 Department of Haalth ei Important: If Item 27 is any injury or other trau once. CEDARDALE ROAD, BALTIMORE, MD# MOSS-wife 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) FOREST VA CEM. 11-25-97 OWINGS MILL GARRISON 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility MARCH FH.-4300 WABASH AVENUE art). Onter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, book, or heart failure. List only one ceuse on each line. Approximete Intervei Between Onset end Deeth **Physician** immediete Ceuse (Finel disease or condition resulting in deeth) /Medicai Examiner Examiner physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es a consequence of) usa ò ed by the s P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed hes 20 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? TELLA MARIS Be 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence Certification: To 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? ivision 1 DiNaturel 2 Accident 5 Pending 1 Tyes 2 No investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 0 0 Hospital 24 hours a 24 hours a Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es steted.

Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted. 29e. Certifier Medical (Check only one) To the Within 2 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) NOVEMBER 21 1997 140480 erromo 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 7672 Belair Rd FERNANDO 31. Dete filed (Month, Dey, Yeer) FERRO, M Balt mp 21236 32 Pagistrara Signatura Landelle State

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State of Maryland / Department of Health and Mental Hygiene

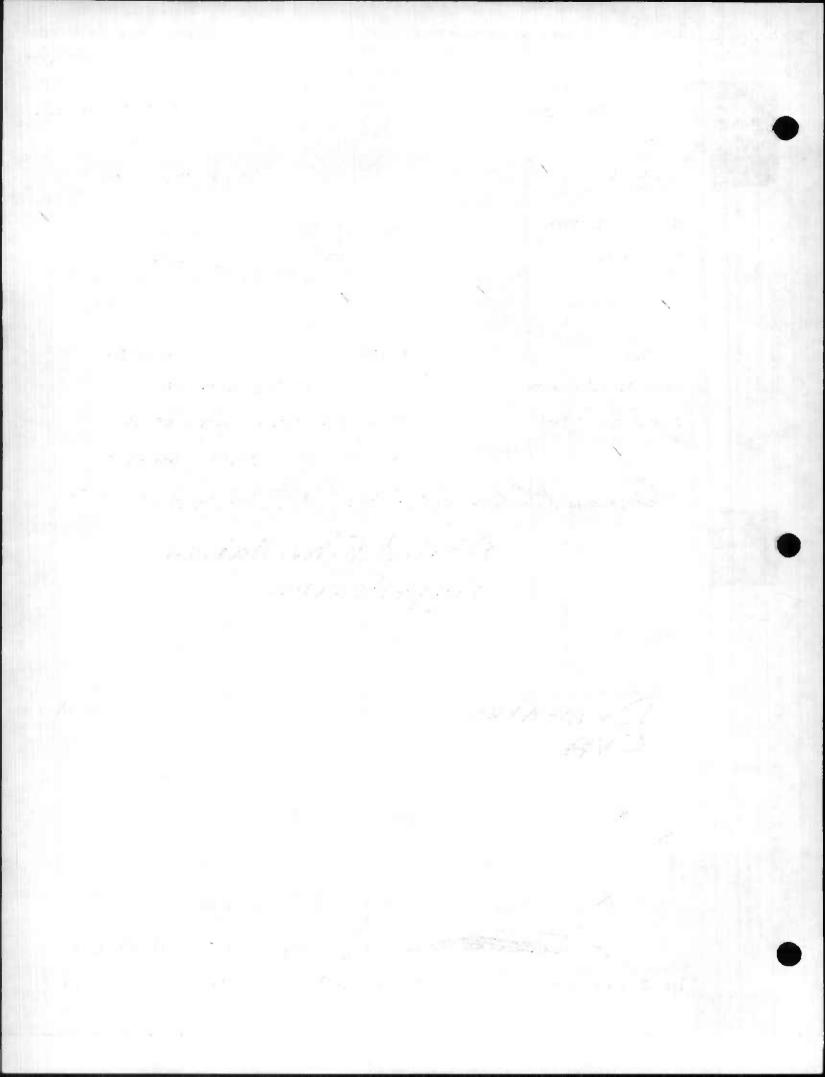
35585 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yaeı **Physician** Roy L. McConnaughy November 1997 18 5:15 P.M. /Medical 4e. Fecility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Daath Examiner Crawell Genesis Nursing Center Baynesville **Baltimore** 5. Social Sacurity Number If Undar 1 Year If Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** 12 M 2□ F Days Hours Yrs. Director 056-10-3515 96 July 31, 1901 Chio Usual Rasidence of Dacedan the Manyland 10a. Stata 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. insida City Limits 1 Yas 2 No Director MD Baltimore Baynesville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 8710 Empe Rd. 21234 U.S.A. death Funeral 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yes 2 Ø No if Yas, Giva Year or Detas; 11. Marital Status Was Decedent of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, etc. hours efter 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yas 2 Z No Specify: Specify à 3 Widowad 4 □ Divorced White Completed 15. Dacedant's Education (Specify only highest grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If item 27 is marked other than "I any injury or other traumatic event, the Mental injury or other traumatic event, the Men Elementary/Secondary (0-12) Collega (1-4or 5+) Unk. Accountant Accounting 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be James E. McConnaughy Linda Alice Griffith 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Jean Hammond/Niece 1410 Dartmouth Ave. Baltimore, MD 21234 20a. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata Chesapeake Crematory 11/20/97 4 ☐ Donation 5 ☐ Othar (Spacity) Beltsville, MD 21. Signature of Funeral Service License 22. Nama and Addrass of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. 2134 Willow Spring Rd. Baltimore, MD 21222 23e. Pert1. Entar the disaasa, or complications that ceusad the disaas. Do not antar tha mode of dying, such as cerdiec or respiretory arrest, shock, or heart feilure. List only one cause on each time. interval Batween Onset and Death Physician il Nation /Medical Immediata Causa (Final disaasa or condition rasulting In daath) Examiner Examiner Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Diseasa or Injury that initiated events rasulting in daeth) Last Due to (ona) a onsequance of) Box 68760. the ettending physician Physician/Medical the Dua to (or as e consequence of): usa as P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 No 3 Probably 4 Unknown Records, by Completed 24a. Was an autopsy performad? 24b. Ware autopsy findings evallable prior to peen completion of causa of daath? We hes page 2 The 2 No certificata 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours after deeth.

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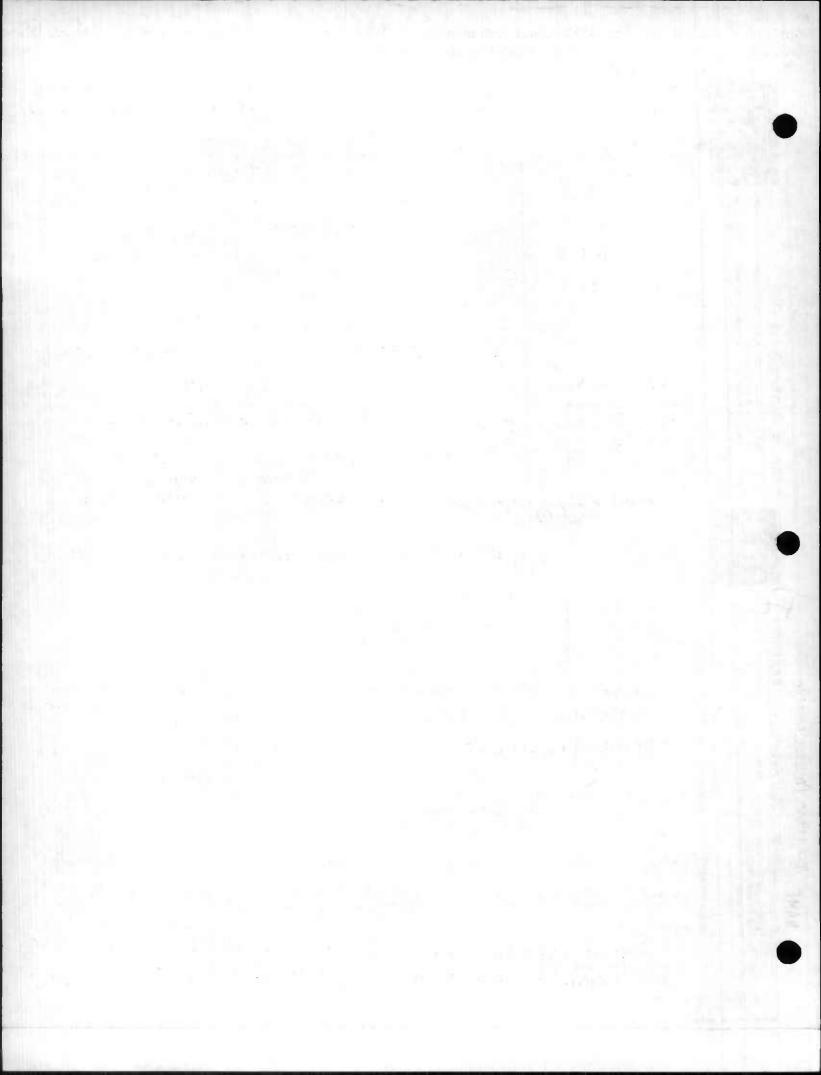
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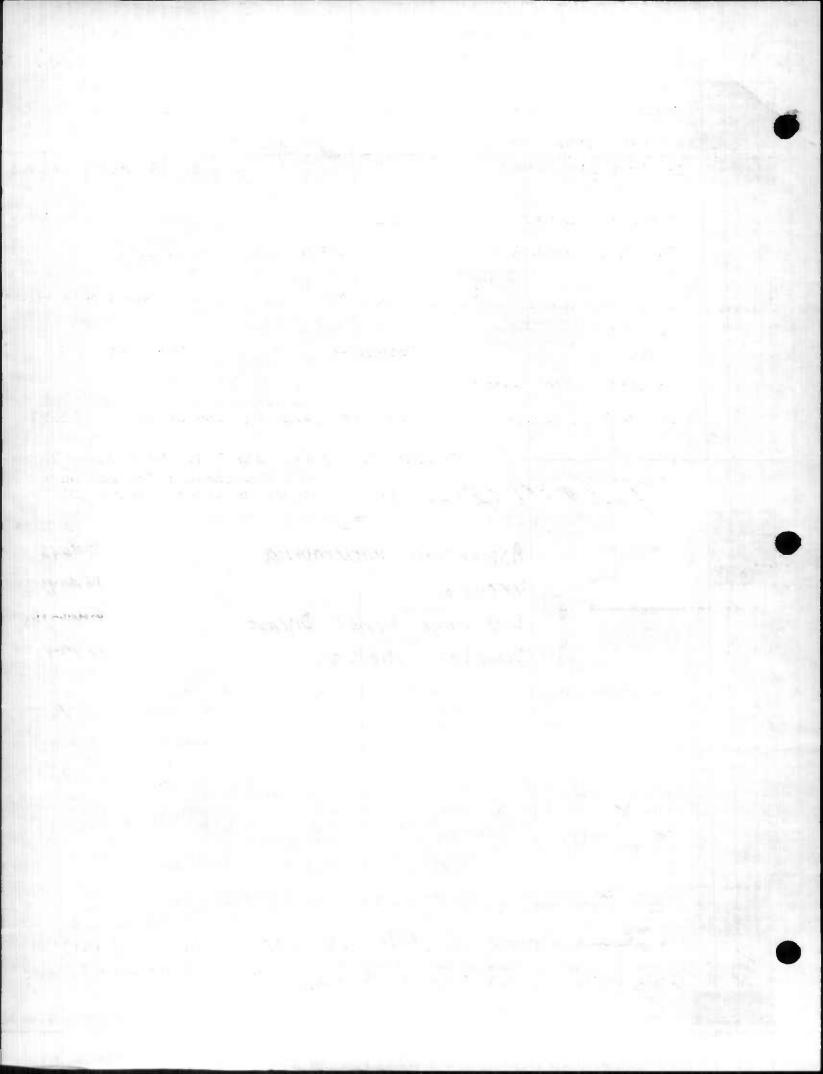
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after Dire	erti	4 Homicide	building	, etc. (Specify)		, radiory, onn			wn, Stete)		
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4		30. Name end eddress of person	who completed cause	of deeth (Item 23e) (Type F	Print)	- 550		TOV CAN A!	101	0. 5- 10
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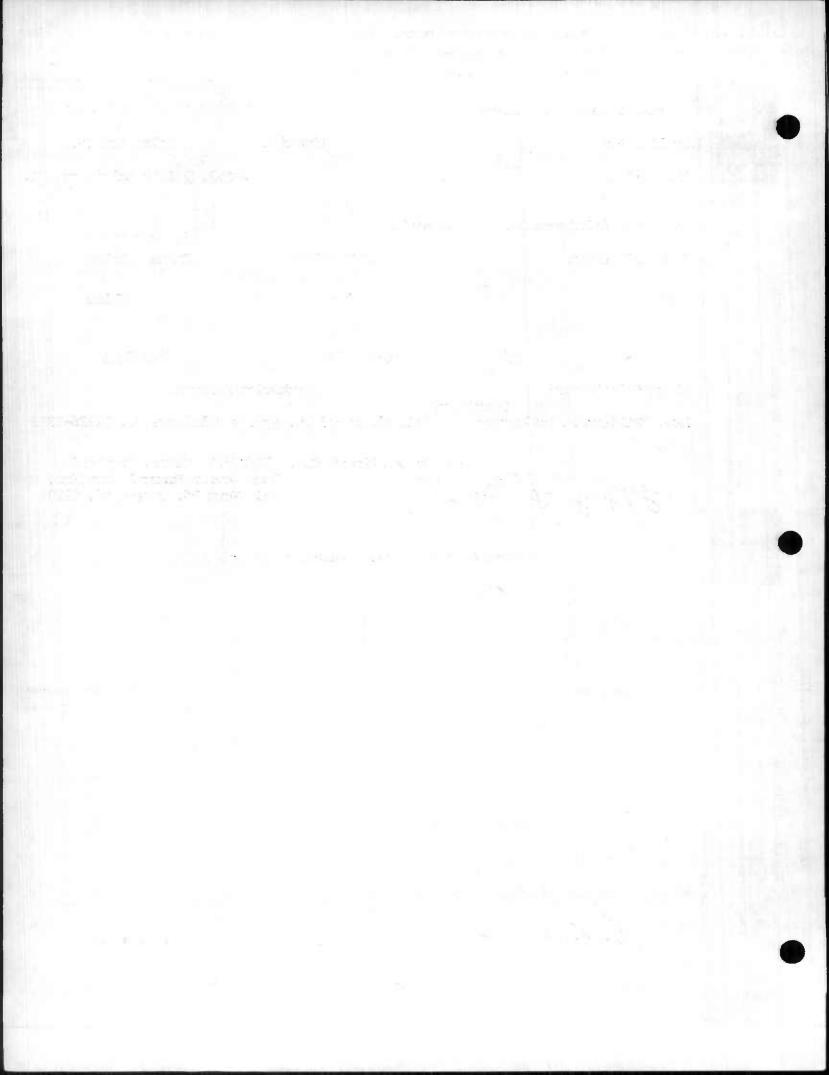
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iner	•	la. Fecility Neme (If not Institution,	give street end nu	m <i>ber</i>)			4	b. City, Town, or	Location of Deat	4c. County	of Death			
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NYQUIST, CATHERINE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month NUGENT MICHAGL 72 2:00PM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death CATONSVILLE BALTIMORE FRANKLIN TREE COURT If Undar 1 Yaar If Undar 24 Hrs. Months Davs Hours Min. 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Dey, Year) 1₽M 2□F Months Days MARYLAND 42 Vre 220-48-1332 JAN. 19, 1955 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 No BALTIMORE 101. Zip Code MARYLAND BALTIMORE 10g. Citizen of What Country? 24 A DEER RUN COURT U.S.A. 14. Race - Amarican Indian, Black, White, etc. 21227 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 CUSTODIAN SOCIAL SECURITY ADMIN. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) WILLIAM J. NUGENT DOLORES M. CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) STEPHEN W. NUGENT, BROTHER 21 FRANKLIN TREE COURT, CATONSVILLE, MD 21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cramation 3 ☐ Removal from State 4 Donetlon 5- Other (Specify) NEW CATHEDRAL CEMETERY 11/26/97 BALTIMORE, MARYLAND 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 21. Signature of Lugeral Service Ligensee 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final 5 mourns CHOLANGIO CARCINOMA disease or condition resulting In death) CNOLANGIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that Initiated events resulting in death) Lest Due to (or as a consequence of) SCIGRUSING CHOUNGITS PRIMARY Due to (or as a consequenca,of) CUCLITIS 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Examiner P.O. Box 68760 Physician/Medicai the à signed be del Records, þ

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Hospital or Attanding Physician:

To the

Be Completed certificate Certification: To this After i efter death.
I Director: Aft

25. Was case referred to medical examiner?

5 Pending Investigation

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1 ☐ Yes 2

27. Manner of Death

2 Accident 3 Sulcide

4 Homlcide

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within 24 hours e To the Funeral C completely filled

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one) Othar: 4 Nursing Home (5) Residence 6 Othar (Specify) 28d. Describe how Injury occurred

28a. Date of Injury (Month, Day Yaar) 28b. Time of 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

Location (Street and Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

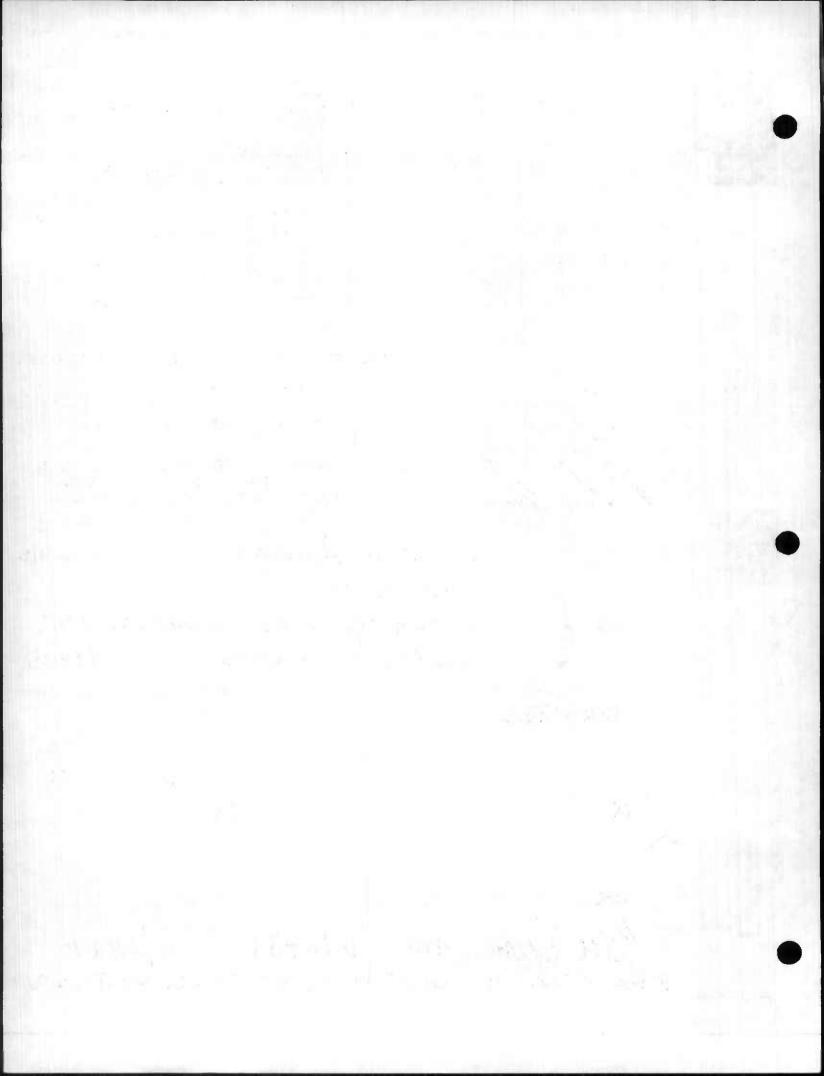
2 | Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certitier 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

ZZS. GREENEST-ZIZO1 DARWIN, MD UNIVOF MS NBWOZ 31. Date filed (Month, Dey, Year)

State Registrar 32. Registrat's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** EDWARD F. PERINA, JR. Vovember 20,199 7:50 AM /Medicai 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** 301 Hospilal Drive North Arrundel Hospital 5. Social Sacurity Number 6. Sax Clew Burnia Burnia 8 A. Co. MARYLAND 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funerai** 220-20-8640 Days Hours 69 Yrs Director MD Usuel Residence of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examener must be notified as MD ANNE ARUNDEL MILLERSVILLE 1 ☐ Yas XXIo Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 8326 BROOKWOOD ROAD 21108 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, etc. 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: XXNavar Marriad 2 Married 1 ☐ Yas 2XXio Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada complatad) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilega (1-4or 5+) Hygiene. CARPENTER SELF EMPLOYED Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be end Mental EDWARD F. PERINA FLORENCE SCHUH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) nt of Health e If Item 27 Is or other trac CECILIA STRICKLAND 9202 STONE SPRING LNE., PASADENA, MD 21122 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) GLEN HAVEN MEM. PK. 11/22 GLEN BURNIE, MD 21. Signatura of Francis Sarvice Ligensee 22. Nama and Addrass of Facility RAYMOND C. FINK FUNERAL HOME 426 CRAIN HWY., SW., GLEN BURNIE, MD 21061 Entar the disease, of complications that ceused the deeth. Do not antar the mode of dying, such as cerdiac or, or heert feilure. List only one cause on each line. Approximate fntervel Between Onset and Death **Physician** 1/2 years /Medical Immediata Cause (Final disaasa or condition rasulting in death) **Examiner** Due to (or es e consequence of) Examiner the buriel-transit Saquantially list conditions, if eny, leading to immadiata ceuse. Enter Undarlying Causa (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or es a consequance of) The law requires that the death certificete be execu P.O. Box 68760. Physician/Medical Dua to (or as a consequanca of) ate hes been signed by the a page 2 should be deteched i Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 ☐ Unknown Obstratia Records, Completed by 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yas 2 No of Vital I or Attending Physician: after death. Director: After this certifica Be 25. Was cese referred to medical examiner? 28. Place of Death (Check only ona) Hospitel: 1 ☐ Impatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 2 In by the funeral 27. Menner of Daath 1 Natural Certification: 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred After Division 5 Panding Invastigation 2 Accidant 6 Could not be determined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 D Homicida 24 hours 1 Cartifying Phyafclan: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Cartifiar 29b. Signature and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 11/20 (47 30. Name and eddrass of person who completed ceusa of death (Item 23a) (Type, Print)

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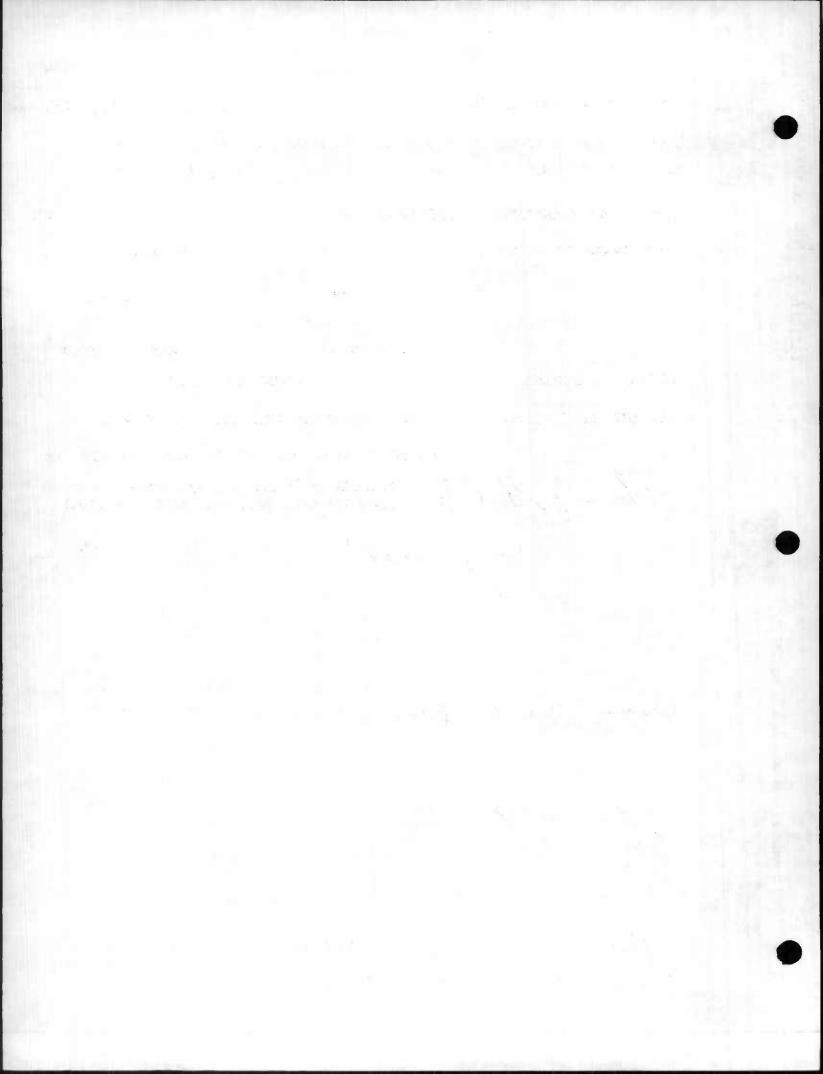
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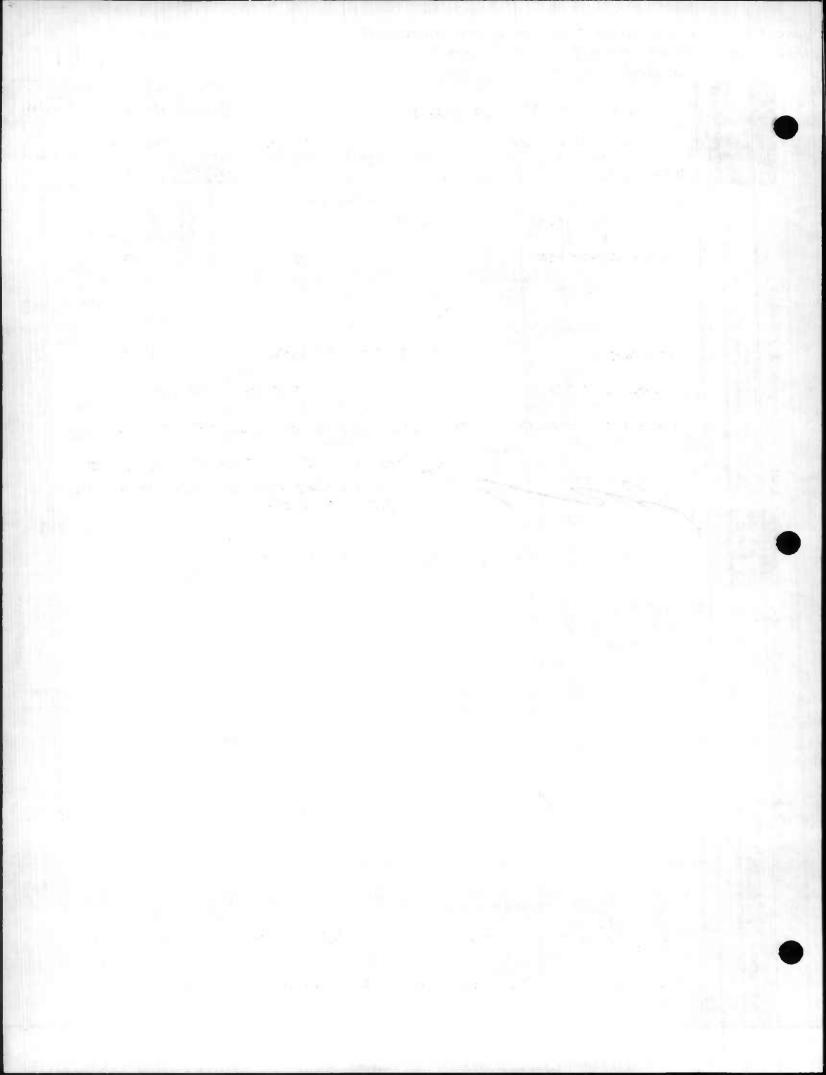
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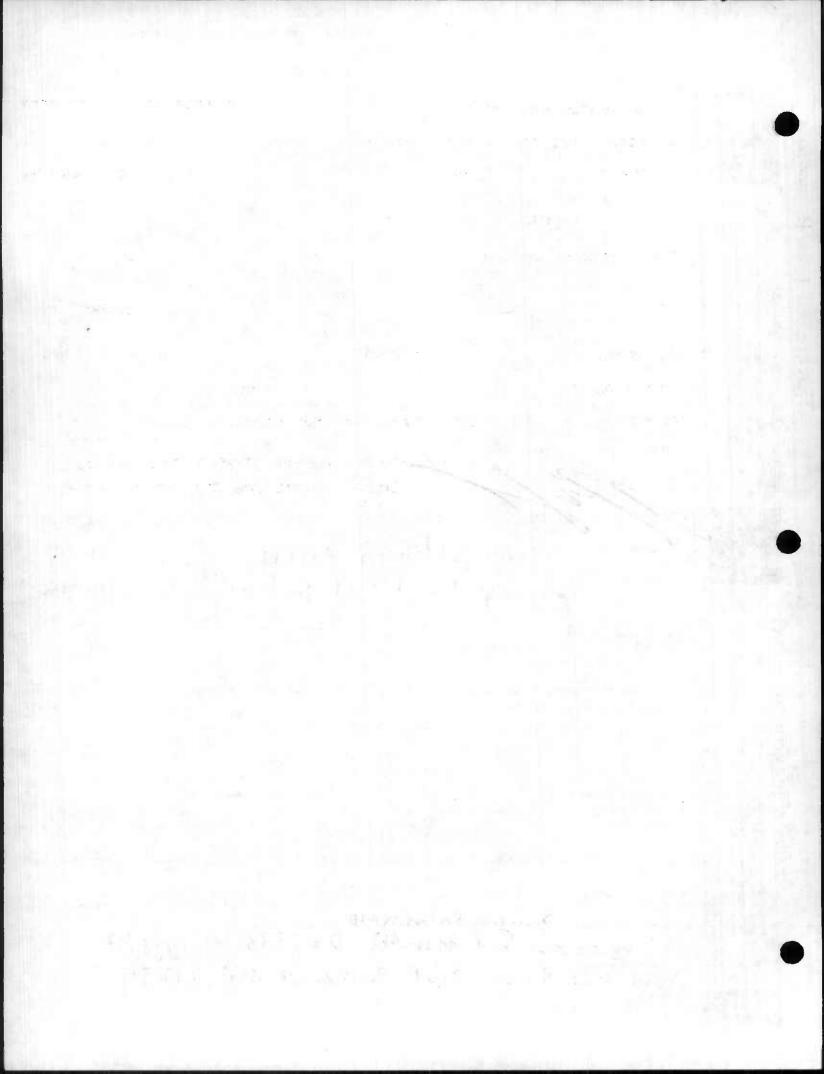
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To the Funeral Direct completely filled in by Medical Certifil	2	9a. Cartifiar 1 Certifyi (Check only one)	ng Phy ÞExami	sician: To the best ner: On the basis o and mannar st	examinati	vladga, deeth o Ion and/or inva	ccurred et the til stigetion, in my c	ma, data and place opinion, deeth occu	, and due to the ca irred et the time, de	use(s) and me ta and ptace,	ennar as ste and due to	eted. the causa(s)
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State Registrar	Ľ	NOV 2 5 1997	,	32. Registr	Son-A	andell						



State of Maryland / Department of Health and Mental Hygiene (1)

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/Medi		JESSIE TA							4b. City, Town, or L		_		11.15
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Maryladd 2 should the and Merker 7 is marker traumetic		19a. informant's Name/F	Raiationship	(Type, Print)		19b. N	Aailing Address	s (Street	t and Number or Rui	al Route Numbe	ar, City or Town	, Stete, Zip	Coda)
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Q		30. Nama and address of	person who	Completed causa	of daath (Iter	n 23e) (Ty	pe, Print	(1)	more 1	w	2123	9	
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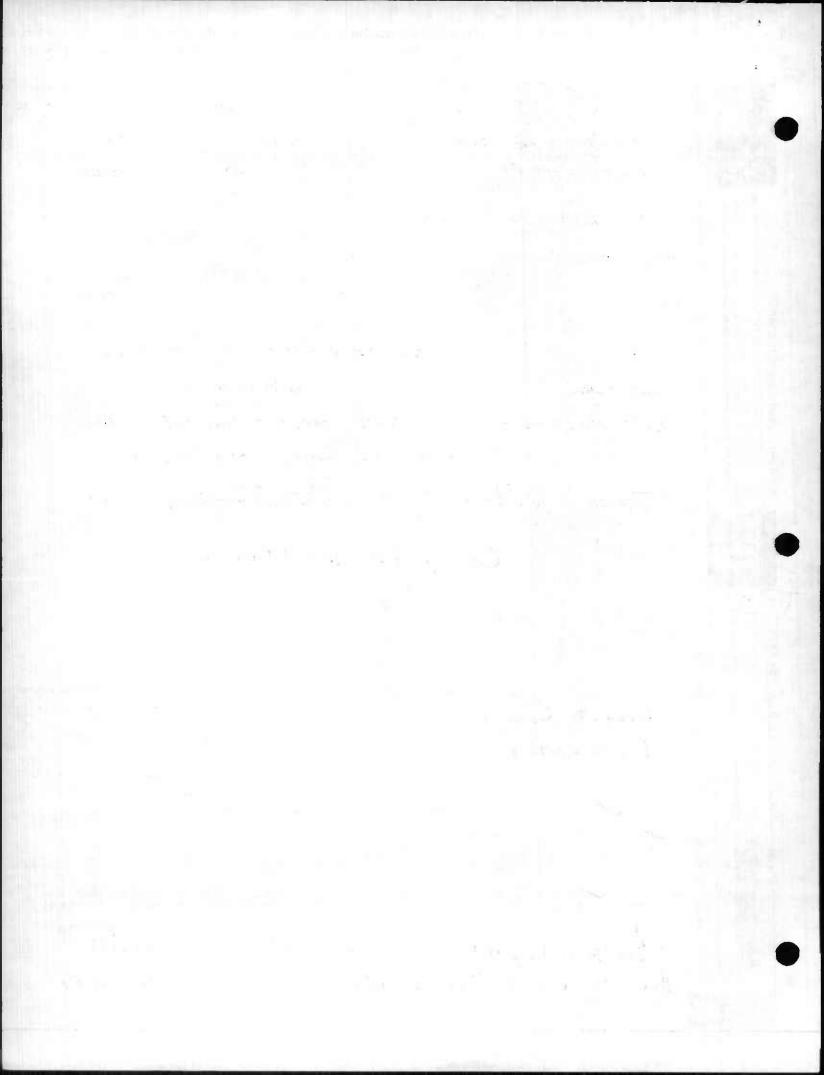
State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Deta of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Month **Physician** Pearl Mary Palmer 23 1997 8:30 pm November /Medical 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crofton Convalescent Center Anne Arundel Crofton If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth Months Deys Hours Min. July 10 5. Sociei Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funerai** 10M 20F 91 Yes 577-44-2221 1906 Director Maryland Usual Basidance of Decadent with the Meryland 10c. City, Town or Location 10e. Stata 10b. County 10d. inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 Yas 2 No Director Prince George Seabrook 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 20706 9411 Woodberry Street U.S.A. death v Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yaar or Detes: 14. Race - American Indien, Black, Whita, atc. 13. Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Marital Status efter 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No White Specify: þ 2 should be filed within 72 hours is end Mental Hygiene.

Is marked other than "natural", o 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Food Service Manager Food Service 17. Father's Name (First, Middle, Last) 18. Mothar's Nema (First, Middla, Maidan Sumama) Be Charles Maske Bertha Mangum Lo 19a. Informant's Neme/Reletionship (Type, Print) 19b. Malling Addrass (Streat end Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 st Department of Health end Important: If item 27 is m any injury or other traun Angelina Ager/Daughter 3727 8th Avenue, Edgewater, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1

Buriel 2 □ Cremetion 3 □ Removel from Stata Resurrection Cemetery 11/26 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funarei Service Licenses 22. Name end Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD ardesu 21401 Mondo 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory errest, shook, or hear failura. List only one cause on sech line. Approximate Intarval Between Onset end Deeth **Physician** immediate Ceusa (Finel disease or condition rasulting In daath) Heart Failure /Medical Due to (or es e consequence Examiner es e consequence of) Examiner Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequença of) physician s the burian Box 68760 90 Physician/Medical thet initieted events rasulting in daath) Last Due to (or es e consaguance of) 88 esn ò P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Did tobacco use contribute to the cause of death? the 6 1 Yes 2 No 3 Probably 4 Unknown Breast Records. by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Completed peen Dementig certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to medical exeminer? Be 26. Pleca of Death (Check only one) Hospitei: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mennar of Death 28e. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Spacify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyelcian: To tha best of my knowledga, deeth occurred et tha tima, data end plece, and dua to the ceuse(s) and menner as stated.

2 Madical Examiner: On the basis of axaminetion end/or investigation, in my opinion, daeth occurred et the time, dete end placa, and due to the cause(s) and menner stated. 29a. Cartifier Medical (Check only one) 29b. Signature and title of certifi 29c. Licensa number 29d. Data signed (Mopth, Day, Year) 1)35848 mplatad cause of death (Item 23e) (Typa, Print) 1438 Defense Huy Gambrills no 21054 32: Redistrar's Signeture

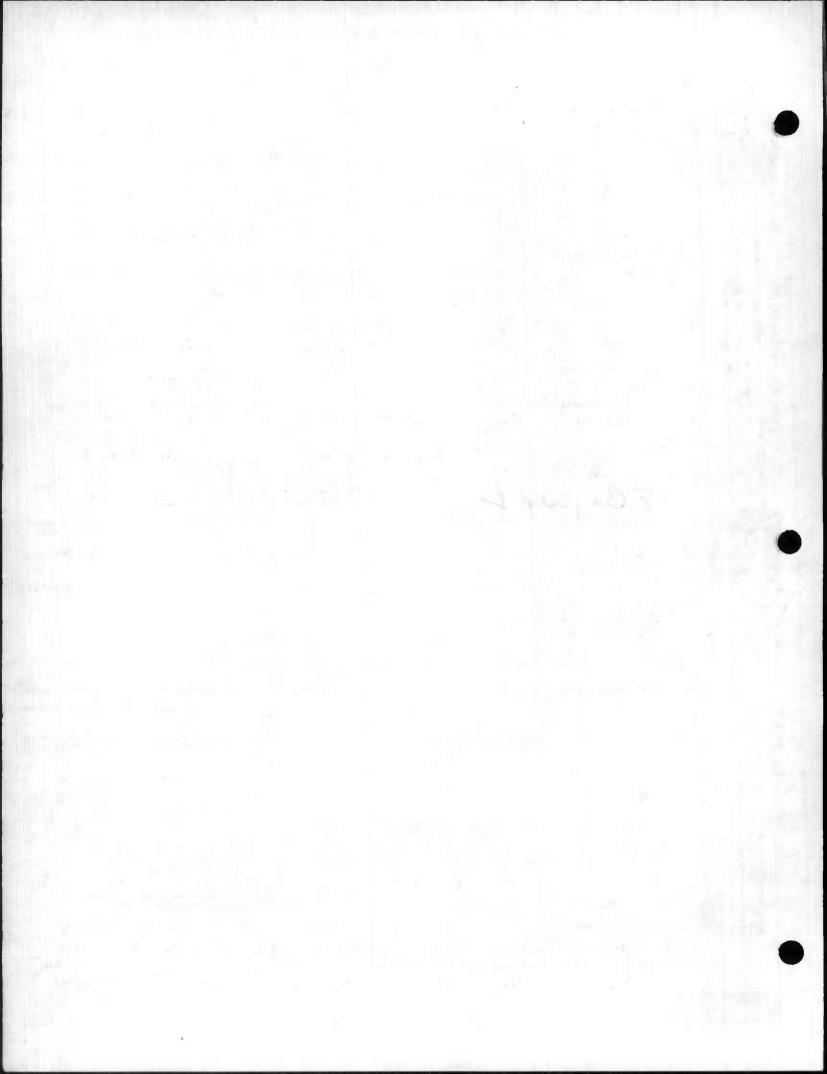
State Registrar



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Deeth 3. Tima of Death **Physician** Month 10:450 EDWIN Pieplow NOU W 9 /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney Montgomery Brooke Grove Nursing Home 7. Aga (In yrs. last birthday) Under 1 Year Under 24 Hrs. a. Data of Birth
OC Months Days Hours Min. (Month, Day, Year) 5. Social Sacurity Number **Funeral** 9. Birthplace (State or Foraign Country) 1X M 2□ F 150-07-0551 86 Yrs. Director May 1, 1911 N.T Usuel Rasidanca of Dacadani the Maryland 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner, must be notified at 10d. Insida City Limits Columbia Howard 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21046 USA 6314 Beechwood Drive 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yes, Giva Yaar or Dates: WWII Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, etc. 11. Marital Status 72 hours after 1 Naver Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 X No Specify: White by Specify: 3 ☑ Widowad 4 ☐ Divorced Completed 16a. Dacadant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highest grada complatad) 16b. Kind of Businass/Industry Hygiena. Elemantery/Secondery (0-12) College (1-4or 5+) U.S. Government Geological Surveyor 12 N/A 12 should be filed w h end Mantal Hygier 7 is marked other th 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be (Unknown) Arthur Pieplow Annette 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 end 2 sh Department of Health end Important: if item 27 is m any Injury or other traum 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Jeffrey P. Pieplow (Son) 6314 Beechwood Drive, Columbia, MD 21046 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Cheltenham, MD 12/1/97 21. Signeture of Funaral Sarvica Licansee 22. Name end Addrass of Facility Witzke Funeral Homes, Inc. Cia 21045 5555 Twin Knolls Rd. Columbia, MD 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batwaan Onsat and Death **Physician** /Medical Immedieta Causa (Final disaase or condition rasulting in death) Heamonia Examiner Due to (or as a consequence of): ractures Saquantially list conditions, if eny, laading to Immadiate cause. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in daath) Last and Dua to (or es a consequança of): De exe 68760 Physician/Medical the Due to (or as a consequence of). 98 Box use for P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records. þ page 2 should b 24b. Wara autopsy findings available prior to complation of causa of daath? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 No certificate Vital or Attending Physician: director Be 25. Wes casa rafarrad to medical 26. Place of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 Yas 2 No of this funeral 28b. Tima of Injury 27. Manner of Death 28e. Deta of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? After Division 5 Panding 1 Natural 24 hours after death.

Funeral Director: Aft letaly filled in by the fur 1 Yas 2 No Invastigation fell From wheelchair. 2) Accident Oct 17 97 UNK. 6 Could not be datarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 3 Suicida 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicida Hill Top Home, Howard CB Croup Home . Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, deta and place, and dua to the cause(s) and mennar as stated.

Medical Examiner: On the basis of exeminetion and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29a, Certifian To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signature end titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) No 30. Name end addrass of person who completed causa of daath (Itam 23a) (Type, Print) John 1 ou ber 8218 WISCONSIN 31. Date filad (Month, Day, Yaar) 32. Ragistrar's Signature State Julia Davidson NOV 2 5 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Day 0, 1997 **Physician** 8:15 PM DOROTHY M. PAYNE November /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Arundel ArundEl HOSPITAL If Under 1 5. Social Security Number 6 Sex . Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1□M 2K)F Yrs. 217-14-1332 Director 81 AUG. 24, 1916 MARYLAND Usual Residence of Decedant 10a State 10b County 10c. City, Town or Location ms 23a or 28a-f show 10d. Inside City Limits Director MARYLAND ANNE ARUNDEL T.TNTHTCIM 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 GROVERIDGE CT. 21090 UNITED STATES Itams 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas: Was Decadent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Nevar Married 2 Married "natural", or 1 Yes 2X No Specify: Specify: by 3 ☐ Widowed 4 🗓 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER CHEMICAL Baltimore, Maryland nent of Health end Mental Hy It: If Item 27 is marked 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be (UNKNOWN) FREEMAN DOROTHY (UNKNOW) 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) JACULYN L. LOUKE / DAUGHTER 401 GROVERIDGE CT., LINTHICUM, MARYLAND 21090 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata NOVEMBER 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department of important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) GLEN HAVEN MEM. PK. 22, 1997 GLEN BURNIE, MARYLAND 21. Signatura of Fun 22. Name and Address of Facilit KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E, GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on aach line. Approximate Interval Between Onset and Death **Physician** Preumonia /Medicai Immediate Cause (Final 20 diseese or condition resulting in death) Examiner Due to (or as a consequenca of) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated avents resulting in death) Lasf Due to (or as a consequence of): be execu 68760, Physician/Medical Due to (or as a consequenca of) Box signed by the e Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? o 1 | Yes 2 No 3 | Probably 4 | Unknown Records. à been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed page 2 1 Yes 2 No certificate 1 □ Yes 2 □ No Vital Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ 16 1 ☑ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA Division of this funeral Certification: 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of is or Attending Pater death. Director: After to in by the funera 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 | Homicide 24 hours e pletely filled

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State Registrar 29a. Certifier (Check only one)

29b. Signature and fitle of certifier

ENZAYAT, MT

31. Date filed (Month, Day, Year) NOV 2 5 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ENZAYAT, MD NORTH ARUNDEL HOSPITAL 32 Flug strar's Signature widson-Pindo 20

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) end manner es steted.

2 Medicaf Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29c. Licansa number

D 51443

29d. Date signed (Month, Day, Year)

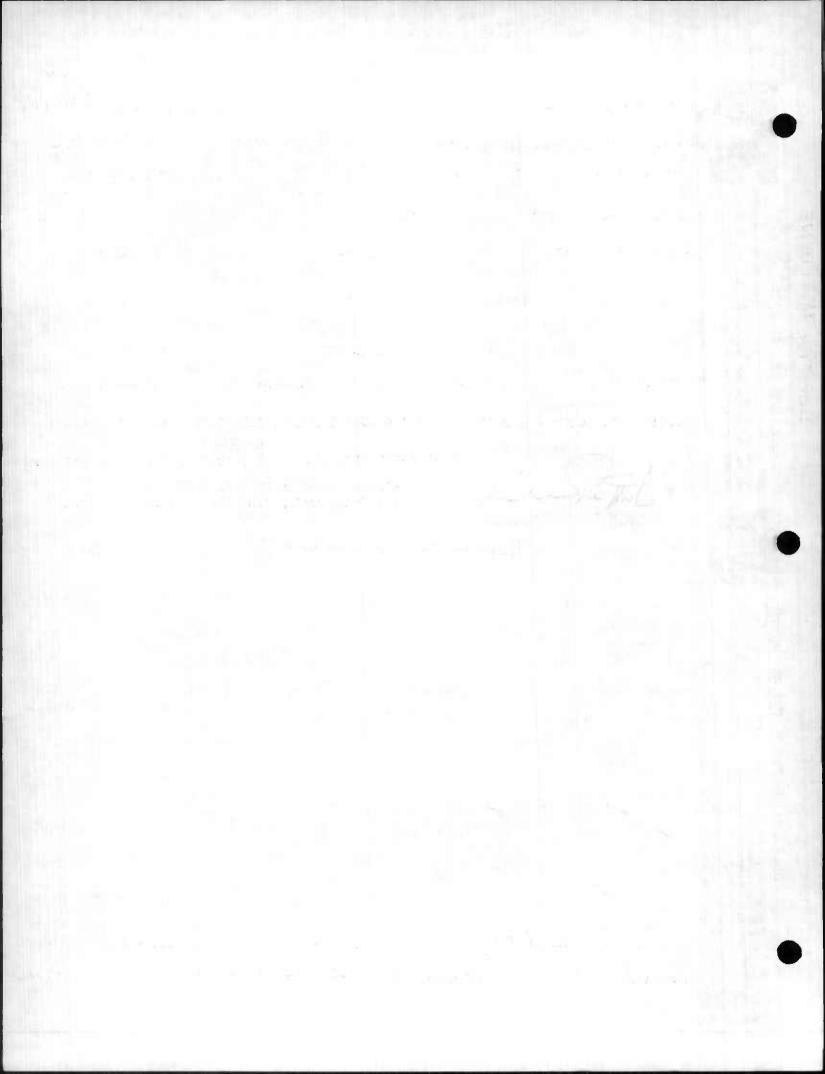
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301 HOSPITAL DRIVE GLEVBURNIGIND 21541

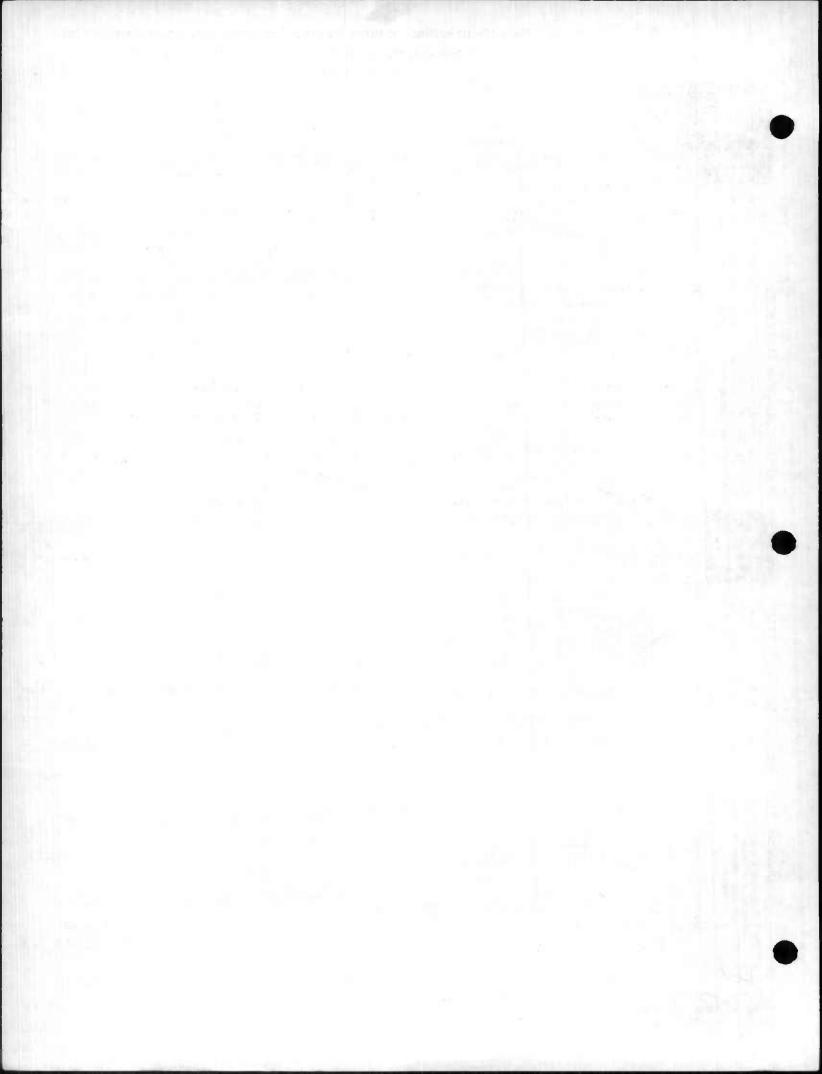
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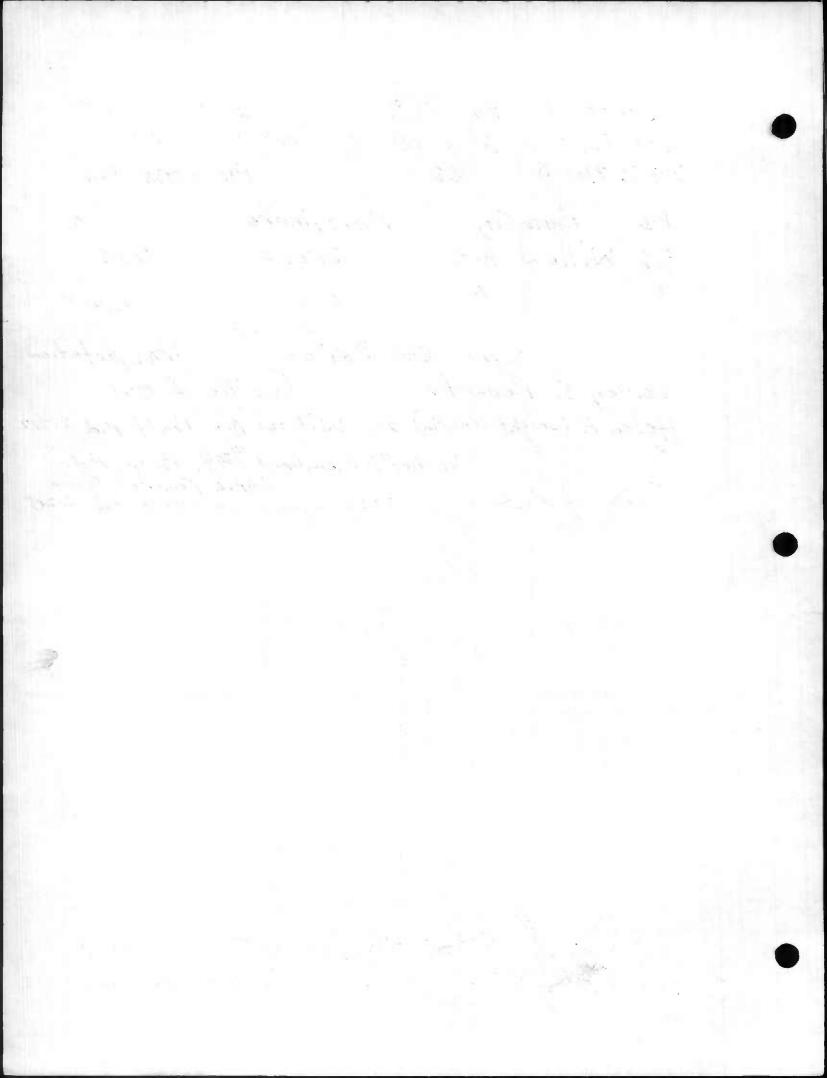
Johnson



		Decedent's Neme (First, Middle, Las	State of Mary		ertificate of		2. Date of Do	Reg. No.		5596
Physiciar /Medica		Cecelia Pr	uski				Month	20	Year 97	3. Time of Death
Examine Funeral Director	er	4a. Facility Name (If not Institution, give Loch Ravea A 5. Social Security Number 212-10-5119	russing Cen	Ter yrs. lest birthde; 1 Yrs.	y) If Under 1 Yeer Months Days		County	th 4c. County Balt	timore	e (Stete or Foreig land
how	o	Usual Residence of Decedent 10a. Stete 10b. County Maryland Baltimore		: City, Town or I		ore City				Inside City Limit
23a or 28a-f should be notified at	al Direct	10e. Street end Number 4821 Sinclair Land	9		10f. Zip Code	21206		10g. Citizen of W	/hat Country	7
9 8 8	by Funeral Director	11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forcas? 1 ☐ Yes ② No If Yes, Give Year or Dates:	in U,S. 13	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spean, Mexicen, Puerto Specify:	pecify Yes or No Rican, etc.)		e - American k, White, etc. : White	
important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Madical Examiner once. To Be Commissed by Euro	Completed	15. Decedent's Ed (Specify only highest grade Elementery/Secondery (0-12) 8th grade	coetion fe completed) College (1-4or 5+) N/A	(Giv life.	edent's Usual Occu re kind of work done DO NOT use retire	pation during most of work od)	king	16b. Kind of Bu		
rked other	lo Be C	17. Fether's Neme (First, Middle, Last) Feliks Pruski				18. Mother's Nam		, Meiden Sumem		
27 is main or trauma		19a. Informant's Name/Relationable (7 Mary F. Dixon	ype, Print)			Avenue Ba				ode)
ant: if Itam ury or oth		20a. Method of Disposition X₁ □ Burlal 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specify	Removel from State	cemetery, cri	coaltion (Name of emetory or other ple edral Cen	netery 11-	Dete -24-97	20c. Location - Baltimor		
any inj		21. Signature of Funeral Service Licent	00			ess of Facility Uneral Ho ir Rd. Ba		Md 21	236	
strian and set the burla-transit as the burla-trans	icai Examiner	Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due b	to (or as a conse	equence of):					nset end Death
igned by the attending pt be deteched for use as it by Physician/Med		Part II. Other significant conditions co	d	resulting In the	underlyling cause gi	ven in Pert I.	23b. Did	tobacco use con	tribute to th	e cause of deat
s been signe 2 should be d	2						24a. Was	Yes 2 No s an autopsy ormed?	24b. Were evella	eutopsy findings ble prior to letion of ceuse ath?
director, page		25. Was cese referred to medicel examiner?				26. Place of Dea		Yes 2 No	1 □ Y	es 2 No
neral di	2	1 Yes 2 No 27. Manner of Death 1 Shaturel 5 Pending 2 Accident Investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Dey Yea		of 28c. Inju			idence 6 Other		
To the Funeral Director: Af completely filled in by the furnities of the formal Medical Certification		3 Suicide 6 Could not be determined	28e. Place of Injury - / building, etc. (Sp	ecify)			City or To	(Street and Number own, Stete)		
the Funer npletely fil		(Check only 2 Medical Exami	elcian: To the best of my nar: On the basis of exan and manner stated.	knowledge, dea nination and/or i	nvestigetion, in my	opinion, deeth occur	and due to the red at the time	, date and place, a	ind due to the	e cause(s)
com	-	29b. Signeture end title of certifier Berclar Karok	al, M.D.		29c. Licen	se number +7813		29d. Date signed		v. Yeer) 1997
0		30. Neme and eddress of person who co	ASH 3007	(Item 23e) (Type E. No. h	Print) Por	ال يوسك	allimore	L MD	21214	+
State Registrar		31. Date filed (Month, Dey, Year)	July David	ignature	00	•				

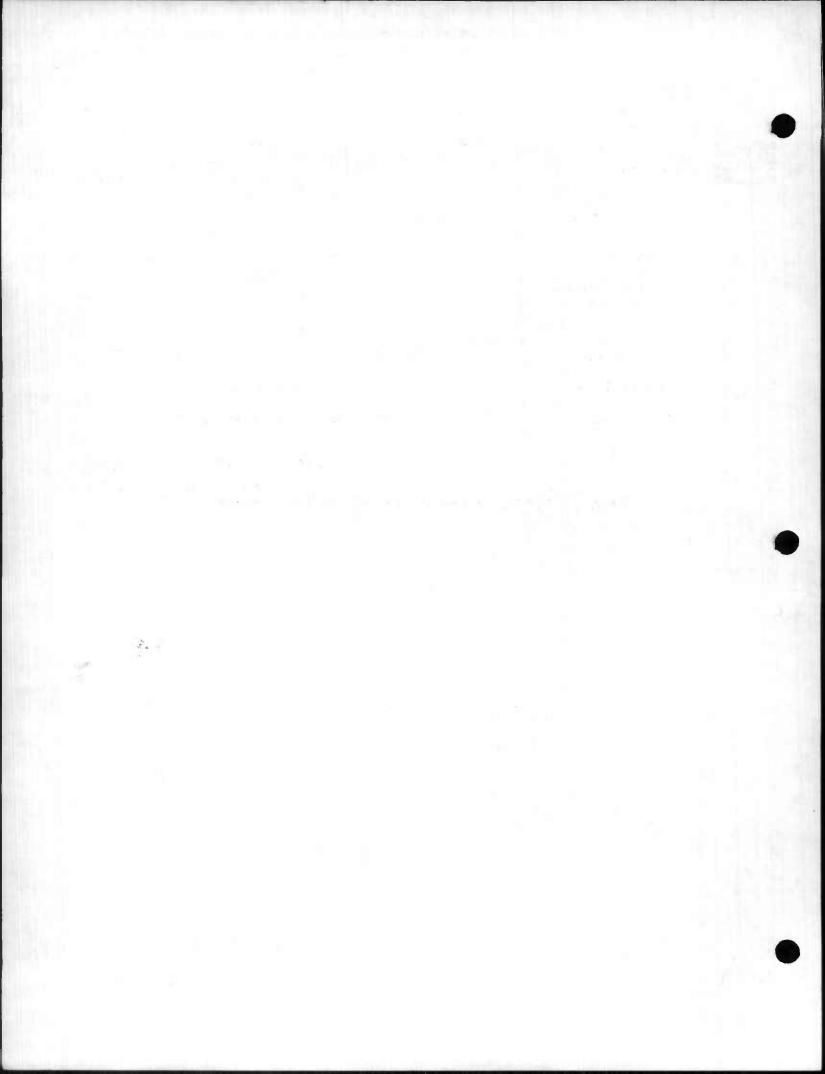


		State of Maryland / Department of Health and I		ene 9 7	35597
Physicia	n	1. Decedent's Neme (First, Middle, Last)	2. Dete of Deeth Month	Dey Yesr	3. Time of Death
/Medica	-	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or the street and number of the street an	0	4c. County of Deal	th th
		LORIEN TRANKFORD NVRSING CENTER BA	CIO,	NA	shalon (Otal a Faria
Funeral Director		219 32 9300 MM 2 F 62 Yrs. Months Days Houra Min.		1935	tholace (Stete or Foreign
ahow		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	,		10d. Inaide City Limits
the Maryla 28a-f ahor notified at	ector	10e. Street and Number 10f. Zip Code	6	- Ohion - Clare - C	1 Yes 2 No
23a or	a Di	516 Willow Ave 21212	-	g. Citizen of What Co	A
d 21215-0020 filed within 72 hours after death with the Maryland thygiene. ther than "natural", or thems 23s or 23s-4 show ont, the Modical Examiner must be notified at	Funeral Director	11. Maritel Status 12. Was Decedent Ever In U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (S If Yes, apecify Cuban, Mexican, Puert I 1 Yes, apecify Cuban, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Rece - Ame Bleck, Whit	
21215-0020 d within 72 hours aft giene. r than "natural", or r the Medical Exam.	þ	3 ☐ Wildowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☐ Ye		Specify: 13	/ack
215- thin 72	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 16a. Decedent'a Usuai Occupation (Give kind of work done during most of worling. DO NOT use retired)	rking	6b. Kind of Business	Andustry
d 212. filed within Hygiene. mther then	Cou	17. Fsther's Name (First, Middle, Last) 18. Mother's Nen	me (First, Middle, M.	ANSP	ortation
Maryland 212 d 2 should be filed within the and Mental Hygiene. T is marked other then traumatic event, the Mental the control of the control	To Be	Dorsey S. Roberts Luc	sille.	Sutton	
CEN		19a. informant's Name Relationship (Type, Print) 19b. Mailing Address (Street end Number or Ru 19c. Mailing Address (Ave	City or Town, State, 2	Zip Code) hd 2/2/2
P T T T T T T T T T T T T T T T T T T T		20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, crematory or other place)	Days 2	Oc. Location - Oity or	164
Baltimo	-	4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Icensee 22. Name and Address of Facility A	129/97	134/10,	Ad.
Balt permit. Departn Imports any ink		1 Delal 5502 Winner	Ave f	Bulto P	V8VICE V1 21265
Physician		23e Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac ahock, or heart feiture. List only one cause on each line.	or respiratory arres	il.	Approximate interval Between Onset end Deeth
/Medical Examiner		Immediate Cause (Final disease or condition a Corplinal Vascular A	cciden	义—	IMONTH.
PH 17 0	Je.	resulting in death) a. Due to (or as a consequenca of):			
and and li-transit	Examiner	Sequentially list conditions, if eny, leading to immediate			
68760, ficate be ex	dical	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of):			
Box 68 leath certifical attending plant of the ast attending plant.	w	d			<i>t</i>
ords, P.O. Box (requires that the death certif een signed by the attending hould be detached for use a	Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld tob	acco use contribute	to the cause of death?
es that the lgned by the be detache	2 Ku	Dementia	1 1 Yes	2 □ No 3 □ P	robably 4 Unknown
Records,		Multiple CVA'S	24a. Was an parform	ed?	Ware autopsy findinga available prior to
	Completed	Peripheral Vascular Disease	1 ☐ Yes		completion of cause of death?
of Vital In	20	exameter?	eth (Check only one		10165 20160
수 등을 나	0	27. Manner of Death 28a. Date of Injury 26b. Time of 28c. injury at	lome 5 Residen		cify)
Division or Attending F after death. Director: After I in by the funer	Catio	2 Accident investigation M 1 Yes 2 No	005 Landing (0)		10 111
Div	Certification:	4 Homicide determined 26e. Placa of injury - At home, farm, street, fectory, office building, etc. (Specify)	City or Town,	eet and Number or Ru State)	urai Houte Number,
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edicai	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece 2.	, and due to the cau rred at the time, dat	ise(s) and manner as le end place, and due	a atated. e to the cause(s)
To the within To the complete		29b. Signature and title officertifier 29c. License number	29	d. Date signed (Month	th, Day, Year)
n	9	30. Name and address of person who completed cause of death (item 23a) (Type, Print)	5	1/24/9	1/
		FREDRIC S. SIRKIS M.D. 7151 HOLABIR	DAVE.	BALTO. 1	MD, 21222
State	1	31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature			



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's	Name (First, Mic	ddle, Last)					2. Dete of D			3. Time of Dea	ath
sician	Dor	is V	irginia	R:1	24			Nevem	Day Day	Year	1:29/	Sm
edical miner	4e. Facility Na	me (If not institu	tion, give street end)		4b. City, Town, o			++++		
	H	arbor	rlospital	(enter			Beltin	nore		N/A		
al Ir	5. Sociel Sacu 219187	7492	6. Sax 1 □ M 25 F		s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of B (Month, 2 July 16	irth Jay, Year)	14420000	lece (Stete or Fol try)	reign
	Usuel Resider	10b. Cour	nty	10c. C	City, Town or Lo	cation				1	0d. Inside City Lie	mits
ō	Maryland	d Anne	Arundel	В	altimore					1	1 □ Yes 2 🔯	
Funeral Director	10e. Street en	d Number				10f. Zip Code			10g. Citizen of	Whet Coun	try?	
a D	317 Hail	Le Ave				21225			U.S.			
Iner	11. Marital Sta	itus	12. Wes D	acedent Ever in Forces?	U,S. 13. V	Was Decedent of	Hispenic Origin? (ban, Mexican, Pue	(Spacify Yes or Norto Ricen, etc.)		ce - Americ		
y FL		Married 2 ☐ M red 4 ဩ Divorc	arried 1 ☐ Ye	s 2 1 No Giva No		I□Yes 2√No		,	Speci			
Completed by				r Detes:	16a Deced	lent's Usual Occu	ination		16b. Kind of E			
piet		Specify only higi Secondery (0-12	ent's Education hest grede complete	ed) e (1-4or 5+)	(Give	kind of work done OO NOT use retire	during most of w	rorking	Tob. King of E	003111033/1110	lustry	
E O		h Grade	College	9 (1-40r 5+)	Secret	ary			Hecht Con	mpany		
Be (17. Father's No	ema (First, Middl	e, Last)				18. Mother's Na	ama (First, Middl	le, Meiden Sumai	ma)		
2		ll Fisher					Iris S					
To Be Comple		t's Name/Relation Riley/S	nship (Type, Print)				nt end Number or F ad, Pasader			, Steta, Zip	Code)	
	20e. Method o	-		20b.	Place of Dispos	sition (Neme of		Data Data	20c. Location	· City or To	wn State	
	1 D Burial	2 Crematio	n 3 Ramoval fro	m State	cemetery, cren	netory or other pl		Data	Zoc. Location	- City of 10	WII, State	
once.		ion ¹ 5 ☐ Other of Funeral Service		Hi:		vice Corpo		11/21/97	Towson,	Maryla	nd	
Suce	16/	4	m7	A company	12.		. (Gonce Fune		me P.A.	
	23a. Pert1. Er	ntar the disease,	or count (cations that	at ceused the dea	ath. Do not ente	Ol Ritchie or the mode of dy	Highway,	Baltimore ec or respiretory	e, Md 21225 errest.	5	Approximate	
an	shock, or	r heart failure. L	one cause of	n eech lina.							Approximate Interval Between Onset and Death	n n
al	Immediate Ce disease or cor	ndition		Pheumi	b inc					1	2 2045	
er	resulting in de	ath)	θ	Due to	(or as e conseq	uence of):					1	
edicai Examiner			b .	Acute	Renal	Failure				i	3 9942	•
xan	Sequentially li	st conditions, to immediate		Due to	or as a conseq	uence of):					1	
ie i	Sequentially life eny, leading ceuse. Enter Cause (Disease that Initiated a	Underlying se or injury	c							i		
ğ	resulting In de	ath) Last		Due to (or es a consequ	uence of):				1		
NZ.			d							-		
Physician/W	Pert II. Other s	Ignificant condi	tions contributing to	death but not ra	sulting In the un	nderlying ceuse a	iven In Part I.	23b. Did	d tobacco use co	ontributa to	the cause of de	ath?
/ Phy	A		Myocardia	: (orction			1	Yes 2000	3 Prot	ably 4 Unk	nown
b		ica ic	Tigocar cur	at the	316110.	,						
Completed								24e. Wa per	s en eutopsy formed?	ava	re eutopsy findin illeble prior to npletion of ceuse	
jdu									/	of o	leath?	4
								1 🗆	Yes 2 No	1	Yes 2000	
o Be	examiner?	referred to medic	Hospital: V	1		_ 0	hor:	eeth (Check only				
I-	1 ☐ Yes 27. Manper of	2 Mo Death	11		28b. Time of	3 DUA	4 □ Nursing	1	sidence 6 Otl		')	
tion	1 VNatura 2 ☐ Accide	1	ding (Me	ta of Injury onth, Day Year)	Injury	28c. Inju Wo M 1	ork?]Yas 2∐No					
Certification:	3 ☐ Suicid	a 6 □ Coul	mined 289. Pia	ice of Injury - At I	nome, farm, stre	eet, factory, office		28f. Location	(Street end Num	ber or Rura	Route Number,	
Cert	4 L Hollic	de	bul	ilding, etc. (Spec	rry)			City or 10	own, State)			
	29e. Certifier (Check onl	1 Certify	ring Physician: To the Examinar: On the	he best of my kn	owledge, deeth	occurred at the t	ime, dete end plac	e, end due to the	e ceuse(s) and m	anner as st	eted.	
Aedical	one)		and me	enner stated.	ation and/or inv			arred et the time				
Σ	29b. Signature	and title of certif	ier L	0.0	10 10 10	29c. Licen	sa number	14	29d. Dete signe	ed (Month, I	Dey, Year)	2
		ame	2 NOW	ayour	my	A>	24416 nover s	0/1	Novembe	Y 1	. 199	
		address of posses	n who completed so	wood of dooth /tte	m 23a) /Tuno (Drint\			- 4			
	30. Neme and	TID on F.	5 Hopol	yski	2001	S, Ha	no vor	st Ra	1+ , m , v-	mp	21225	-



and / Department of Health and Mental Hygiene	0	en ş
Certificate of Death Reg. No.	9	1

BOWMAN ROGER			State of M	larylar		artment o			Mental Hy	/giene Reg. No.	97	35599
Physici /Medic		1. Decedent's Name (First, Middle, I	Boman W	Valte:	r Roge:	rs III			2. Dete of D Month NOVEMI	eath Day	Year 6.1997	3. Tima of Death
Examir		4e. Fecility Name (If not institution, g)				4b. City, Town, o	r Location of Dea		4c. County of Death	
Funeral Director		217 52 7354	Sex 7. A 1X M 2□ F	ge (In yrs. 49	last birthday) Yrs.	If Under 1 Y Months D	ear ays	If Under 24 Hi Hours Min		rth ay, Year) , 194	9. Birt	thplace (State or Foreign ountry) aryland
r 28a-f show	tor	Usuat Residence of Decedent 10a. State 10b. County Maryland N/A			y, Town or Lo							10d. Inside City Limits 1 Yes 2 □ No
th with the 23a or 28a	rai Director	10e. Street end Number 724 S. Oldham S	treet			10f. Zip Co	de	24			en of Whet Co	puntry?
5-0020 72 hours efter death with the Maryland natural, or Hams 23a or 28a-f show asset Examiner must be notified at	by Funeral	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	Ever in U No Viet	ful ii	Was Decedent If Yes, specify 1 ☐ Yes 2 🔀			Specify Yes or N rto Rican, etc.)		4. Raca - Ame Btack, Whit		
within ane.	Completed					dent's Usual O kind of work d DO NOT use n	Occupetion done during most of working retired)			16b. Kin	findustry	
and be file of othe event,	To Be C	17. Father's Name (First, Middle, Las		18. Mother's Name (First, Middle, ogers Jr. Anna Tull					, Maiden S	Maiden Sumame)		
CHNF		19e. Informant's Name/Relationship Donna Maenner /						and Number or F	Rural Route Numb			Zip Code) and 21230
O S TO I		20a. Method of Disposition 1 Buriat 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			emetery, crer	sition (Neme on atory or other	r pla		Dete 11/20/9		eation - City or wnsvill	Town, State Le, Maryland
Baltimo permit. Pag Depertment Important: It eny Injury o		21. Signature of Funeral Servica Lice	,	ho		Name end A		,	Gonce l	Funer	al Home	P.A.
Physician /Medical Examiner		23a, 11. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting In death)	y one cause on each i	ine.	n. Do not ent	er the mode of	f dyii	ng, such as cardi	ela- E	errest,		Approximete Intervat Between Onset and Death

Due to (or as a consequence of):

Physician/Medical Examiner P.O. Box 68760, The law requires that the death certificate be ay the usa as Division of Vital Records, by 2 page 2 should Completed this cartificata To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cardifica completely filled in by the funaral director, it Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably MUnknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Yes 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or tovestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Wes case referred to medicat examiner?

1 XYes 2 □ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

29c. License number

OCME

29d. Date signed (Month, Dey, Year)

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

NOVEMBER 17, 1997

Dennis J. Christe m 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

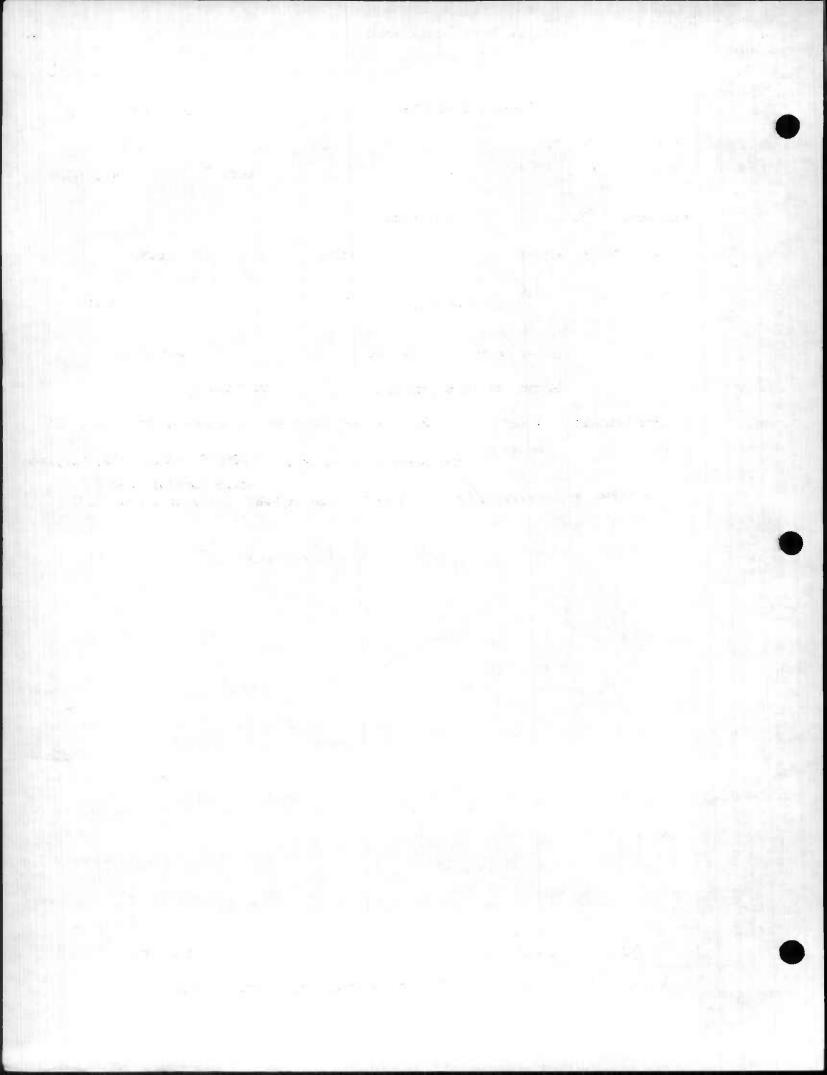
State Registrar

Medicai

5 Pending Investigation

6 Could not be determined

32. Registrar's Signature

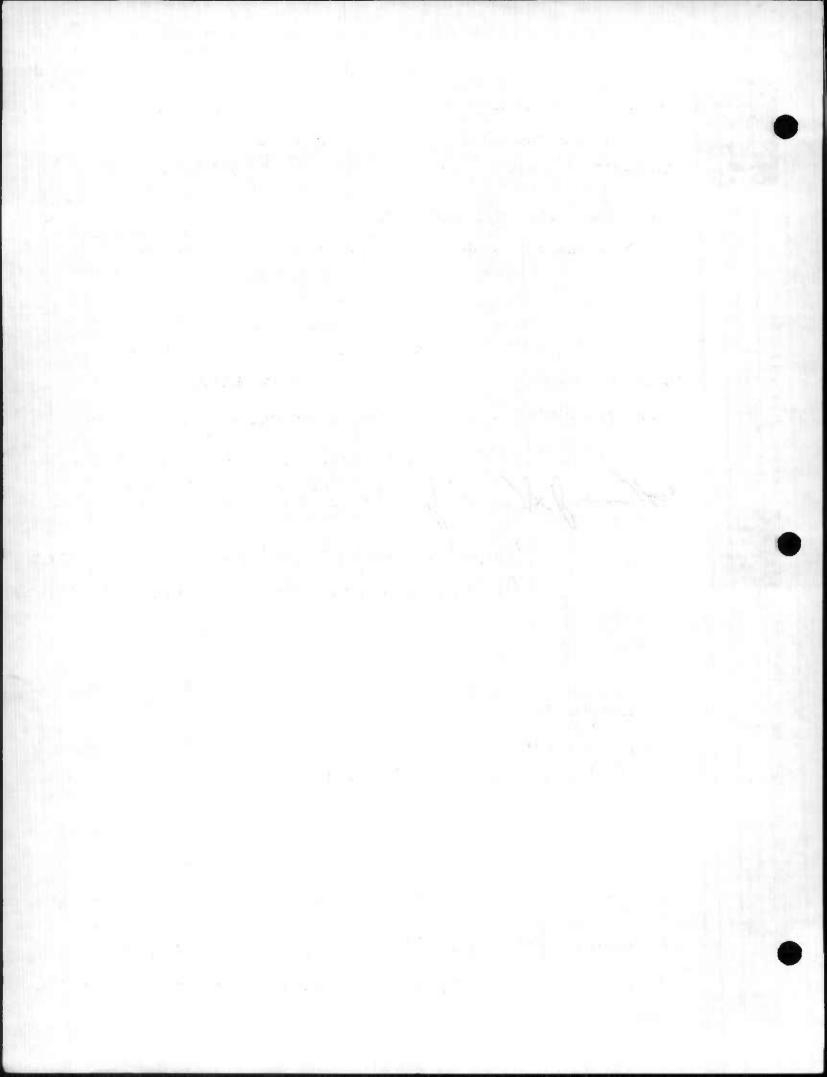


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month NOV. Dey 1997 **Physician** 13, MARY J. RYCHWALSKI 7:30 P.M. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HAMMONDS LANE NURSING HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Days 1 M 2 TF 217-05-3975 89 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumetic event, the Maorca Examiner must be notified at MD ANNE ARUNDEL GLEN BURNIE 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 934 POINT PLEASANT ROAD 21060 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 if Yes, Give Yeer or Dates: 1 Yes 2 XNo Specify: WHITE by 3€Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumetic. Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be JOSEPH RYCHWALSKI JULIA DZIBEK 19a. Informant's Name/Relationship (Type, Print) NORMAN J. RYCHWALSKI 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 934 POINT PLEASANT RD., GLEN BURIE, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata Warial 2 ☐ Cremetion 3 ☐ Removel from State GLEN HAVEN MEM. 11/17 PK. 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE. 21. Signature of Foreral Service Lig 22. Name and Address of Facility RAYMOND C. FINK FUNERAL HOME 426 CRAIN HWY., GLEN BURNIE, 21061 23a. Part1. Enter the disease, shock, or heart failure. Little Do not enter the mode of dylng, such as cardiac or respiretory errest, Approximate Interval Between Onset and Deeth Physician /Medical immediate Cause (Final disease or condition resulting in death) Examiner DISPRSE The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last and P.O. Box 68760. attending physician Physician/Medical the Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PSIS Records, by 24b. Were autopsy findings evellable prior to Completed 24e. Was an autopsy performed? nemia completion of ceuse of death? Altzheimertxpe Dementiq 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital tal or Attending Physician: The star death.

Ill Director: After this certificate ed in by the funeral director, pa Be 25. Was cese referred to medicel examiner? 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | William Home 5 | Residence 6 | Other (Specify) 10 1 Yes 2 No 28c. Injury et Work? 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending Investigation 1 Natural 1 Tes 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dil completaly filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steted.
2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) THE 1710 Pennington Ave Balt more Md. 21226 OLVIN ar 31. Date filed (Month, Day, Year) NOV 2 5 1997 State NOV 25 Registrar

DHMH 16 Bay 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35601 Items: 8.12 per F.H. G-754 12/1/97 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month BINSKI STANLEY 5.55 PM /Medical 4e. Facility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** BALTIMORE (0000) SAMARITAN HOSPITAL BALTIMURE If Under 24 Hrs. 8. Date of Bath (Month, Car) 6. Sex 1 S M 2 ☐ F 7. Age (In yrs. lest birthday) 83 Yrs. If Under 1 Year 5. Social Security Number Birthpiece (State or Foreign Country) **Funeral** Months Days 212030284 Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE Director 10g. Citizen of Whet Country? 6 7306 YORKTOWNE U.S.A itams 23a 21204 Funeral 12. Was Decedent Ever in U,S. Armed Forces? **MYes 25 He Yes, Give Yeer or Dates:1940-1945 14. Race - American Indien, Bieck, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Pages 1 and 2 should be filled within 72 hours effernent of Health end Mentel Hygiene.
Int: If item 27 is marked other than "natural", or its 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: A 3 Widowed 4 □ Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) WESTERN ELEC. ACTORY WORKER 17. Father's Name (First, Middle, Last) STE KOWALEWSKI 19a. Informent's Name/Relationship (Type, Print) Depertment of Health er important: If Item 27 is any injury or other trau BALTIMORE, MD. 21204 20b. Place of Disposition (Name of cemetery, cremetory or other place) INDV 20c. Location - City of Town, State 20e. Method of Disposition Burial 2 Cremetion 3 Removel from Slate 4 Donation 5 Other (Specify) 1997 BALTO. CO. MD STANISLAUS CEM. 3218 HUDSON ST 21. Signature of Famoral Service & censes MD. 2124 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cadio Pulmonary arrest 15 minuts /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) 7-10 days. Examiner Sepsis Sequentially list conditions, if any, leeding to Immediate ceuse. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): P.O. Box 68766 cheto physiclan Perforated Colon Physician/Medical the Canterof 950 Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? page 2 1 Yes 2 No 1 Yes 2□ No Division of Vital sepital or Attanding Physician: hours effer death. meral Director: After this certifice director, Be 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 inpatient 2 □ ER/Outpetient 3 □ DOA funeral 28a. Date of Injury (Month, Dey Year) 28c. injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 - Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piace, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated. Medical 29e. Certifier

State Registrar

5

31. Date filed (Month, Day, Year)

29b. Signature end title of certifier

32. Registrer's Signature

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

mo

29c. License number

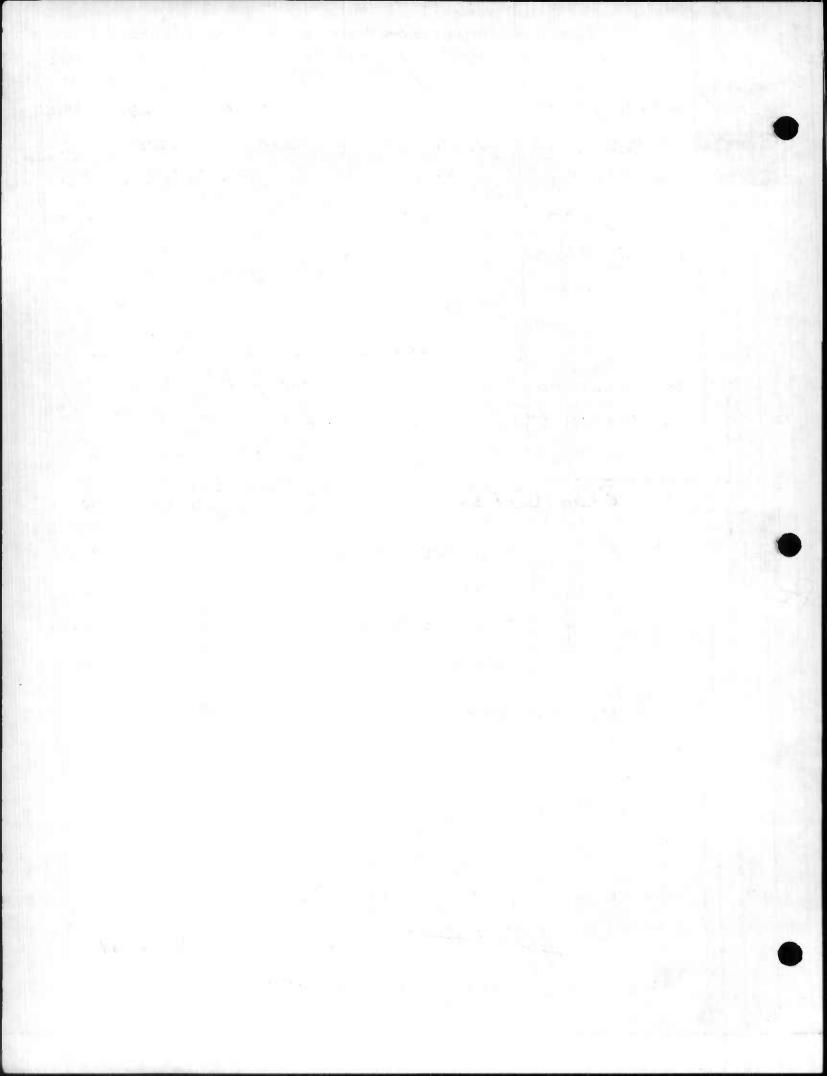
29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cert	ificate of	Death		Reg. No.	7 35602
hysician		1. Decedent's Neme (First, Middle, Walter E	Last) Rhod					2. Date of D	. Day	3. Time of Deeth
Medical xaminer	-	la. Fecility Neme (If not institution,					4b. City, Town, or	Worker Location of Dee		y of Deeth
xammer	ı	CHURCH HON				4 3	BALTO		No. Count	N/A
neral ector		5. Social Security Number 6	1. Sex 7. Ag	je (In yrs	iest birthday) Yrs.	If Under 1 Year Months Deys		. (Month, D		Birthplece (State or Foreig Country)
ector		237-26-1141 Usuel Residence of Decedent		, ,				MAR 7,	1920	NC
ad at		10e. State 10b. County	/-	10c. City	y, Town or Loca	tion				10d. inside City Limit
Director	3		N/A			BAI	LTO			1 X Yes 2 No
		10e. Street end Number	N GE #O	0.0		10f. Zip Code			10g. Citizen of	Whet Country?
Aner munt	5	1400 E. MADISC	12. Was Decedent	Ever in U.	S. 13. Wa	212(as Decedent of		Specify Yes or N		ce - American Indien,
P A	5	1 Never Merried 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 if Yes, Give Year or Detes:	No		es, specify Cul	Hispenic Origin? (: ben, Mexican, Pue Specify:	rto Rican, etc.)		rck, White, etc.
t, the Medical	2	15. Decedent's (Specify only highest)	Education		16e. Deceder	nt's Usuel Occu	petion	orkina	16b. Kind of B	lusiness/Industry
mple		Elementary/Secondary (0-12)	College (1-4or	5+)			during most of wa ed)	nknig	TN IIC	HCE
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To Be	5	UNKNOWN								ne/
To		19e. Informent's Name/Reletionship	(Type, Print)		19b. Meiling	Address (Stree	et end Number or R	YDIA RE		, Stete, Zip Code)
		AUDREY JOHNSO	N		89 JU	рттн т	OR CORAL	M. NV 1	1727	
e no s	1	t0a. Method of Disposition 1x Burlai 2 Cremetion 3	□Removel from State	20b. P	iace of Disposit emetery, creme	ion (Neme of	ece)	VOV 23	20c. Location	- City or Town, Stete
ei ei		4 Donetion 5 Other (Spe	cify)	EV	ERGREE			1997		RN, NC
OUC.		21. Signeture of Funeral Service Lic	ensee	-	CAR MO	lame end Addr OLINE RTUARY	ST BALT	ETTS FU	NERAL 21213&	HOME 1129 N. OSCAR'S BURN, NC28562
edical Examiner		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease of Injury het initiated events esuiting in deeth) Last	. Sepsi	Due to (or	es e conseque	nce of):	2	5		
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plete		<u> </u>						24e. Wes	s en eutopsy ormed?	24b. Were autopsy findings evallable prior to completion of cause of death?
Comp								10	Yes 200 No	1 ☐ Yes 2 ☐ No
5 0		5. Was case referred to medical exeminer?	/					eth (Check only	one)	
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2		7 11	28a. Dete of inju	Year)	28b. Time of injury	28c. inju Wo		28d. Describe	how Injury occur	red
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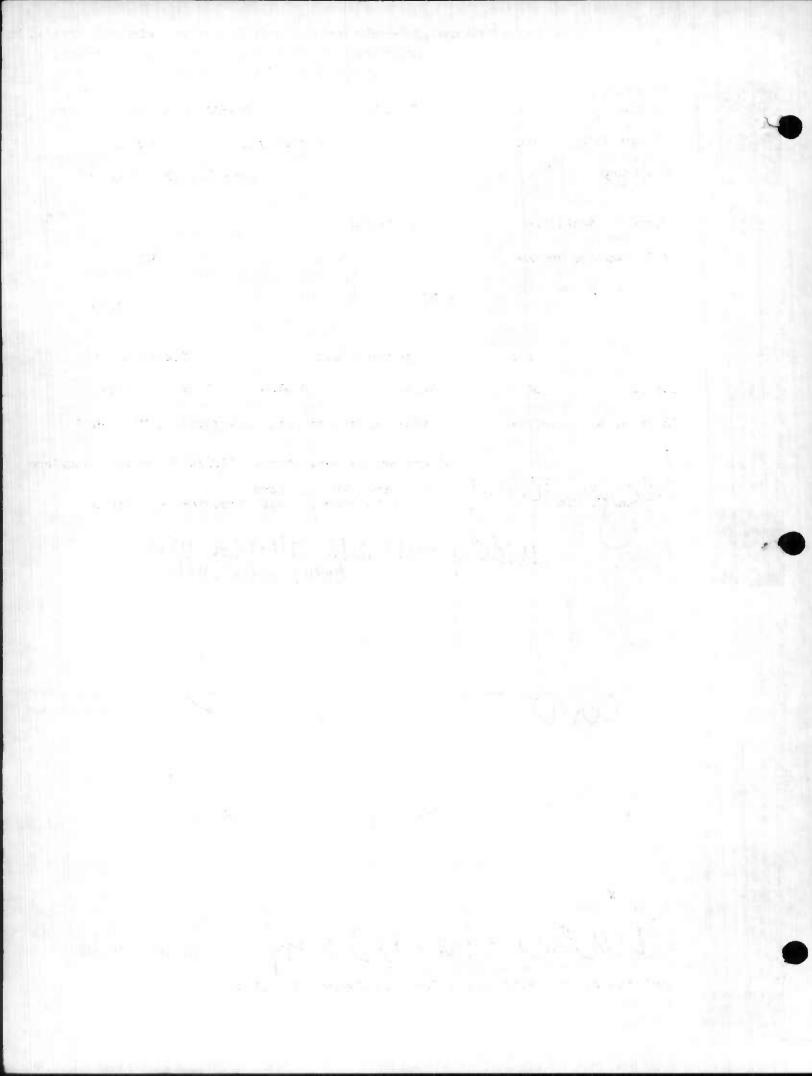
		Decedent's Name (First, Middle, Last	orate or iviary		Certifica				Reg. No.		3. Time of Death		
Physic	lan	RALPH J. RICHARDS						Month	Day	Year			
/Med		4a. Facility Name (If not institution, give					4b. City, Town, or	NOV Location of Death		of Death	9:50 AM		
Exami	mer			TAT					,				
Funeral	Т	HOWARD COUNTY GE 5. Social Security Number 6. Se		n yrs. lest b		ler 1 Yeer		8. Date of Bir	HOWAI		ace (State or Foreign ry)		
Director		395-07-3788 Usual Residence of Decedent	Ø M 2□ F	79	Yrs. Month	s Days	Hours Min	Dec. 31	y, Year) 1, 1917	Count	PA		
/land		10a. State 10b. County	10	c. City, To	wn or Location					10	d. Inside City Limits		
a-f sh	tor	MD Howard	đ	Col	umbia						1 ☐ Yes 2 💢 No		
th with the 23a or 28 unt be no	al Director	10e. Street and Number 10351 College Squ	are		10f. 2	Zip Code 210)44		10g. Citizen of V USA	What Count	ry?		
15-0020 72 hours after death with the Maryland "natural", or flems 23s or 28s-f show solical Examiner must be notified at	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW			edent of I becify Cub 2 X No	Hispanic Origin? (Sean, Mexicen, Puer Specify:	Specify Yes or No to Rican, etc.)	Blac	e - Americe ck, White, e	itc.		
215-0 hin 72 ho n "natur Medical	ete	15. Decedent's Ed (Specify only highest gree		168	a. Decedent's Us	sual Occup	pation	rkina	16b. Kind of Bu		ustry		
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be filed tall Hygie d other i	Be C	17. Father's Name (First, Middle, Last)						me (First, Middle,		ne)			
arylan should be ind Mental marked o	10	Ralph J. Richards	on					et Fitz					
		19a. Informant's Name/Reletionship (7 Mary Richardson	ype, Print) (Wife)				e Square,			Stete, Zip 6 21044			
Baltimore, permit. Pegas 1 and Department of Heall Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Stete	cemete	of Disposition (A ery, cremetory of 11 Crema	r other ple		ov . Date 19, 1997	20c. Location -				
Ballt permit. Departr Importu any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc.											
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	icetions that the difference on each line.	death. Do	not enter the m	TW11	1_KIOLLS ng, such es cardie	c or respiretory a	rest,		21045 Approximate Interval Between Onset and Death		
/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death) ACUTE RESPIRATORY FAILURE Due to (or as e consequence of):											
1 ₹ ₹	Examiner		sepsis							2-	-3 DAYS		
68/60, tificate be axecuted g physician end as the burial-transit	хап	Sequentially list conditions, if any, leading to immediate		consequence o									
68 / 60, ificate be axecul g physician end as the burial-trar	alE	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	PNEUMONIA (LEFT LUNG)							2-	-3 DAYS		
ficate ficate phys	edical	resulting In death) Last	Due	to (or as a	consequence of):							
	N/U		d. HYPOTEN	ISION						Н(OURS		
death cere attendir	sicia	Part II. Other significant conditions co	ntributing to death but no	ot resulting	In the underlying	ceuse air	ven in Part I.	23b. Did	lobacco use co	ntribute to	the cause of death?		
that the death cered by the attendir	y Physician/W	CHRONIC ATRIAL FI			, , ,	_			Yes 2□No		ably 4 Unknown		
Kecords, he law requires the hes been signerage 2 should be considered.	Completed by	SLEEP APNEA							an autopsy rmed?	com	re autopsy findings itable prior to ipletion of ceuse eath?		
= + # #	Com	SEIZURE DISORDER						10	res XXNo	10	Yes 2□ No		
Or VITAL Physician: The this certificate and director, page	Be	25. Was cese referred to medical examiner?	Hospital:v			0		ath (Check only o	ne)				
Phys al di	10	1 Yes 2√No 27. Manner of Deeth	1 Lanpatient	2 ER/O	-	JUA		iome 5 Resid					
Attending Phir death. Sector: After the by the funeral	ation	1X Natural 5 ☐ Pending Investigation	28a. Date of Injury (Month, Day Ye	ar) 280.	Time of Injury M	28c. Injui Wo 1 □	rk? IYes 2⊡No	28d. Describe r	now injury occurr	ed			
or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, fi	arm, street, facto	ory, office		28f. Location (S City or Tox	Street end Numb vn, Stete)	er or Rurel	Route Number,		
To the Hospital within 24 hours To the Funeral I completely filled	edicai	29a. Certifier (Check only one) ★★★ Cartifying Phy 2 Madicat Exami	sictan: To the best of my ner: On the basis of exa and manner stated.	mination ar	e, death occurre nd/or Investigation	d at the til	me, date and place opinion, deeth occu	e, and due to the arred at the time,	cause(s) end ma date and place,	nner es sta and due to	ited. the ceuse(s)		
To the To the	Me									d (Month, D			
M		D-16-07 - 171 V								17-97			
10,		30. Name and address of person who HO-LAI FENG, M.D.	1			COL	UMBIA, M	21045					
Sta	ate	31. Dete filed (Month, Dey, Yeer)	32. Registrada				,						



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State of Maryland / Department of Health and Mental Hygiene 9 1 3 5 6 0 4

						Ce	ertificate o	f Death	Reg	, No.		
Physician		 Decedent's Neme (First, Mid 	die, Last)						Dete of Deeth Month	Dey	Yeer	3. Time of Death
/Medical	ı,	JOSEPH		HENRY		ST]	CKLES		NOVEMBER			2:15pm
Examiner		4a. Fecility Neme (If not Institut			er)				Location of Death	4c. County		
	4	10519 Howa 5. Social Security Number	6. Sex		A		If Under 1 Yea	Cockeys ar If Under 24 Hrs		Balti		
Funeral Director		212-28-4852 Usuel Residence of Decedent	1. XX M		Age (In yrs. les	Yrs.	Months Dey			^(ear) 1930	9. Birthp Coun Mary	iece (Stete or Foreign try) Land
Mot to		10e. Stete 10b. Coun	ty		10c. City, T	own or L	ocation				1	0d. Inside City Limits
28a-f shown netting at	5	Maryland Ba	ltimor	9		Cock	ceysville	2				1 ☐ Yes 2 No
		10e. Street end Number					10f. Zlp Code		109	. Citizen of V	Vhet Coun	try?
23a		10519 Howard	d Avenu	ue			210	030		US	SA	
r Items 23		11. Marital Stetus	A	rmed Force		13.	Wes Decedent o	Hispenic Origin? (suben, Mexicen, Pue	Specify Yes or No- to Ricen, etc.)		e - Americ	
<u>د</u> ک	2	1 Never Married 2 Man Married 2 Married 2 Man Married 2 Married	arried 1	Yes 2[Yes, Give Yeer or Detes	195		1 ☐ Yes 2 😿 N			Specify	<i>'</i> :	ite
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To To	-	19e. informent's Name/Relettor						Beula	n Edn ural Route Number, 0		Per	-
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ther	-	20a. Method of Disposition	CRICO/	TIC	20b. Plec		osition (Name of ametory or other p			c. Location -		
늘		1 X Buriel 2 ☐ Cremation		vel from Stat	(0							
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Important: any injury 2000.		21. Signature of Funerel Service	e Licensee	Var	4		2. Name end Add	iress of Fecility ineral Hor	ne			
Importa any inju 2006		23e. Pert1. Enter the disease, shock, or heart tellure. Li			4		O W. Pac	lonia Roa	l, Timoniu	m, MD	210	93
ing physician end 8 es the buriel-transit Medical Examiner	3000	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	6		Due to (or ea	s e conse	equence of):	ray 2	n (9)	1)		
d by the attendi etached for use Physician/		Pert II. Other significant condi	d	ting to deeth	but not resulting	ng in the	underlying cause	given in Pert I.	23b. Did tob	ecco uss co	ntributa to	the cause of death
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page Com									1 ☐ Yes	2 X No	1 🗆	Yes 2□ No
rector, par Be Co		25. Wes cese referred to medic exeminer?	al					28. Plece of De	eth (Check only one)			
0 0		1 ☐ Yes 2 ▼ No	Hospi	tel: 1 ☐ Inpa	tient 2□ER	/Outpetie	nt 3 DOA	Other: 4 Nursing	Home 5 Residen	ce 8 Oth	er (Specify	v)
ner ti		27. Menner of Deeth 1 XNatural 5 ☐ Pend	ling 28	Be. Dete of Ir. (Month, L	pjury Dey Year) 28	b. Time o	of 28c. In	jury et fork?	28d. Describe how	injury occur	red	
the f		2 ☐ Accident inves	tigation				M 1	☐ Yes 2 ☐ No				
al Director: After t led in by the funere Certification:			mined 28	Be. Plece of I building,	njury - At home etc. (Specify)	, farm, s	treet, factory, offic	е	28f. Location (Stre City or Town,		er or Rure	I Route Number,
5 g												
To the Funeral Director: At completely filled in by the furnishment Medical Certification		29a. Certifier 1 A Certify (Check 2 Medics one)	il Examinar: (n: To the bes On the basis and menner:	of examinetion	dge, dee end/or Ir	th occurred et the nvestigetion, in my	time, date end pled opinion, deeth occ	e, and due to the ceu urred et the time, date	se(s) end me e end place,	enner es st and due to	eted. the ceuse(s)
To the comple		29b. Signature and take of certit	11/	1	tool	1/	290 Lice	nse number	290	I. Dete signe	d (Month,	Day, Year)
	1	• uu	MIC	all	NW	10	1/1/0	8594	N	ovembe	r 20	, 1997
		30. Neme end eddress of perso	n who comple	ted ceuse of	deeth (item 23	Be) (Type	, Print)	-01				
		Ruth Kantor	MD 6	5569 N	. Charl	es S	t., Tows	on, MD	21204			
0	_1											
State	1	31. Dete filed (Month, Dey, Yee	V 251	32. Regis	strer's Signature	٠٠ ٢٠	on-Randel)				



State of Maryland /	Department of Health and Mental Hygiene
	0-46-4 50-46

				Department of F Certificate of		Reg. No.	5605
Physici /Medic		Decedent's Name (First, Middle, Last)	Donnal Ray Sm	ith, Sr.	2. Date of D Month NOVEME	Day Year	3. Time of Death 7:05 AM
Examir		4a. Fecility Name (If not institution, give street	and number)		4b. City, Town, or Location of Des	ith 4c. County of Dee	th
		VA MARYLAND HEALTH			FORT HOWARD	Baltimo	
Funeral Director	-	5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last bin	thday) If Under 1 Yeer Months Deys Yrs.	If Under 24 Hrs. 8. Date of B (Month, D) MARCH	irth ley, Year) 9. Bir C	thplace (State or Foreign ountry) St Virginia
P		Usual Residence of Decedent 10e. Stete 10b. County	10c. City, Town	or Location			10d. Inside City Limits
fant f sho	ō	Maryland Balti			Dundalk		1 ☐ Yes 2 ANo
with the Maryland a or 28s-f show Lbe notified at	ect	10e. Street and Number	MOLE	10f. Zip Code	Duildark	10g. Citizen of What Co	ountra?
The with	a D	2804 McComas Avenue		1025	21222	United St	
020 our after death with the Marylar aft, or there 23a or 28a-f ahow Examiner must be notified at	by Funeral Director	1 Never Merried 2 Merried 1	es Decedent Ever In U,S. med Forces? IXYes 2 [] No Yes, Give eer or Detes: Korean	13. Was Decedent of Hif Yes, specify Cube	lispanic Origin? (Specify Yes or Nan, Mexican, Puerto Rican, etc.) Specify:	lo- 14. Rece - Ame Black, Whit Specify: Wh	te, etc.
72 hours	Completed	15. Decedent's Education (Specify only highest grade com	pleted) 16a.	Decedent's Usuel Occup (Give kind of work done life. DO NOT use retired	eation during most of working	16b. Kind of Business	Vindustry
121	mpi		ollege (1-4or 5+)	ille. DO NOT use retired Stocker	d)	Ctool T	- A +
d 2		10 Years 17. Father's Name (First, Middle, Last)		Stocker	18. Mother's Name (First, Middle	Steel Ir	laustry
Baltimore, Maryland 21215-0020 semit, Pages 1 and 2 should be lited within 72 hours at appearment of Health and Mental Hygiene. Appearment of Health and Mental Hygiene, apportant: if Nem 27 is marked other than "natural", or any injury or other traumeds event, the Medical Examples.	To Be	John Smith			Laura Brown	o, motoon cartomay	
re, Marylai a 1 and 2 should b Health and Ment them 27 is marked other traumadic e	-	19a. Informant's Neme/Relationship (Type, Pi	rint) 19b.	Mailing Address (Street	end Number or Rural Route Num	ber, City or Town, Stete,	Zip Code)
e, Me teath ar teath ar m 27 is ther trau		Mrs. Betty L. Smith	n/Wife 2	804 McComas	Avenue Dundal	k, Maryland	21222
or Health		20a. Method of Disposition *□ Burial 2 □ Cremation 3 □ Remov		Disposition (Name of y, cremetory or other plea	Date	20c. Location - City or	Town, State
altimo mit. Pages partment of cortant: If II r Injury or e		4 Donation 5 Other (Specify)		wn Cemetery	11/26/1997	Baltimore	, Maryland
Baltin permit. Pa Departmen mportant any injury ance.		21. Signeture of Funeral Service Licensee		22. Name end Addre Duda-Ruc	ss of Fecility k Funeral Home	of Dundalk,	Inc.
00240		Don't Had	9		e Ave. Dundalk		21222
Shootata		23a. Part1. Enter the disease, or complication shock, or heart tailure. List only one cau	s thet caused the death. Do r se on each line.	not enter the mode of dylr	ng, such as cerdiac or respiretory	arrest,	Approximate tnterval Between Onset and Death
Physician /Medicai		Immediate Cause (Final disease or condition	PNEUMONIA				
Examiner		resulting in death)		consequence of):			2 YEARS
모 생생	iner			and the same of th	ASTASIS TO LU	JNGS	
P760	Examiner	Sequentially list conditions, if any leading to immediate	Due to (or es e o	consequence of):			
60 le buria	E E	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury					
	edical	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):			
Box 6 leath cert attending p	N/M	d					
death death e atter	clai	Part II Other of a Minarch and distance and its					
0 1 5	Physician/M	Pert II. Other significent conditions contributi	ng to death but not resulting in	the underlying cause giv		d tobacco use contribute Yes 2□ No 3□ P	robebly Unknown
M	by P					7108 2010 001	Total y
COFC requir	Completed					s en eutopsy formed?	Were autopsy findings available prior to completion of cause of death?
C 9 - 8	mo:				10	Yes 2⊠No	1 🗆 Yes 2 🗆 No
	Bec	25. Was cese reterred to medicel			26. Place of Death (Check only		
- 5 w 5	To	examiner? 1 ☐ Yes 2 ☐ No Hospite	l: 1 X Inpatient 2 ☐ ER/Out	patient 3 DOA Oth	er: 4 Nursing Home 5 Res	sidence 8 Other (Spe	ecify)
T ge in a		27. Menner of Death 1 Netural 5 Pending 2 Accident investigation	. Date of Injury (Month, Day Year) 28b. T	njury Wor	y at 28d. Describe k? Yes 2 □ No	how injury occurred	
Division of Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined 286	building, etc. (Specify)	m, street, fectory, office		(Street and Number or Rown, Stete)	lural Route Number,
Divisio To the Hospital or Attendif within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	(Check only 2 Madical Examiner: O	To the best of my knowledge, in the basis of examination end of menner steted.	deeth occurred at the tin Vor Investigation, in my o	ne, dete end place, and due to the pinion, deeth occurred at the time	s cause(s) and manner as , date and place, and du	s stated. e to the cause(s)
within 2	Me	29b. Signeture and title of certifier	0	29c. Licens	e number	29d. Date signed (Mont	th, Day, Year)
->-0		2	12m	D30	528	NhV 24	11997
13	- }	30. Name and address of person who complete	ed ceuse of death (Item 23a) (0	100 4 27	
V		BALA S DUGGIRALA,	1.D. 9600 NO	ORTH POINT	RD FORT HOW	ARD MD 21	.052
Sta Registra		31. Date tiled (Month, Dey, Year) NOV 2 5 1997	32/Registrers Signature	dall			

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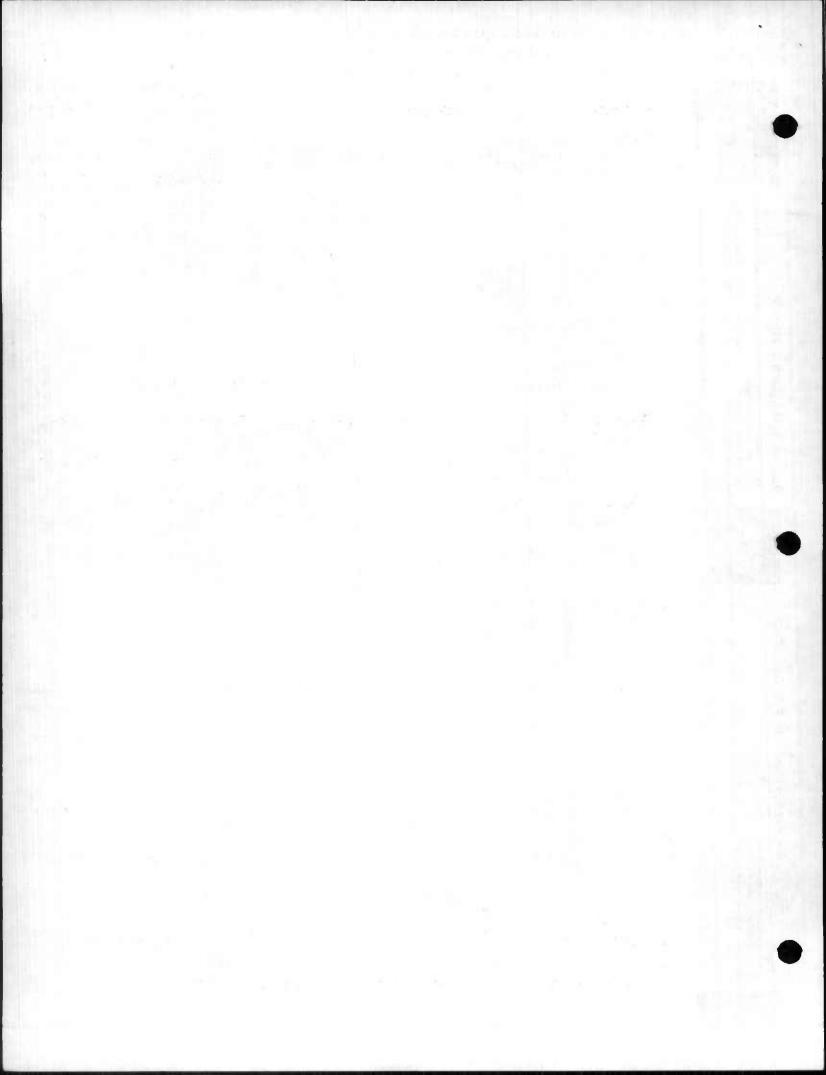
FOR 1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAN .		CEN	HILIC	AIE OF	DEAL	H	REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Leat) MARY A.						2. DATE OF DEATH DA NONTH BER	3. TIME OF DEATH 3:20 A M						
	4. SOCIAL SECURITY NUMBER 2/5-22-9037	5. SEX 6, AG	E (In yrs. lest bir		UNDER 1 YEAR	IF UNDER 2	MIN.	7. DATE OF BIRTH (Month, Day, Year) November 5,1		Country	PLACE (State or Foreign			
	9e. FACILITY NAME (If not institution, give st	treet and number)		9b	CITY, TOWN C	R LOCATIO	N OF DE	ATH	9c. COUNT	Y OF DE	ATH			
DIRECTOR	Wesley Home			Balt	imore			N/A						
RE	10e, STATE 10b, COUNTY		10	Oc. CITY, TO	OWN OR LOCAT	ION					10d. INSIDE CITY LIMITS?			
		/A	E	Balti	more						1 X YES 2 NO			
FUNERAL	10e. STREET AND NUMBER				101	ZIP CODE			10g. CITIZE	N OF W	HAT COUNTRY?			
E I	2211 W. Rodgers A					21209				ted	States			
교	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVE FORCES? 1 YE	S 2 NO)	13. WAS DEC	ENDENT OF	NISPAN Mexican	IC ORIGIN? (Specify Yea 1, Puerto Rican, etc.)	or No- 14	Black,	- American Indian, White, etc.			
B	3 X Widowed 4 Divorced	DATES								" White				
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16e. DECED	DENT'S USU	JAL OCCUPATIO	N of working		16b, KIND OF BUS						
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life, Do	NOT use ret	tired.)	n or worning		Automot		pai	r And			
₹	17. FATHER'S NAME (First, Middle, Last)	9 Vice						Machine Shop						
	Francis Asbury S	tinoboomb						ME (First, Middle, Meiden	Surname)					
BE	190. INFORMANT'S NAME (Type/Print)	LITICICOIID	19b. M	AILING ADI	DRESS (Street e			oute Number, City or Town	State 7to C	ode)				
٤	Mr. Robert K. Sel	lers. Jr. (rest Hill			n			
	20a. METHOD OF DISPOSITION		Ob. PLACE AND	DATE OF D	SPOSITION (Na	me of		7	CATION - CI					
1 X Burlel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) Parkwood Cemetery 11/25/97 Baltimore, M											1ary1and			
	21. SIGNATURE OF FUNERAL SERVICE LIC	S. The			Leonal	rd J.	Ruc	ck, Inc. Fi	uneral	Hoi	me			
\dashv	23. PART I. Enter the diseases, or c	omplications that cause	sed the death	Do not	5305	Harto	rd I	Road Balt	imore,	MD				
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between													
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ACUTE RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF):										Onset and Death			
											ACUTE			
Z	Sequentially list conditions,	DUE TO (OR AS	TIVE	40	VET F	FAILL	1RE	-			ACUTE			
CERTIFICATION											View of C			
SE	CAUSE (Disease or injury	CONGEST	S A CONSEQUE	AT CU	10/140	PMIH	7				YEARS			
E	that thirdson overling										YEAR S			
- 11	PART II. Other algnificent conditions									1				
EDICAL	TART W. Other alignment controls	s contributing to death	Dut not resu	iting in tr	ne underlying	ceuse gl	ven in i	Part I. 24a, WAS AN a PERFOR		1	WERE AUTOPSY FINDINGS			
								t TYES 2	, mo	(COMPLETION OF CAUSE OF DEATH?			
Σ	DID TOBACCO USE CONTR	ZIBLITE TO CALISE	OF DEATH	YES	NO V	UNCE	DTAIL			1	1 YES 2 NO			
¥	25. WAS CASE REFERRED TO MEDICAL	COULTO CAOSE			check only one)	OIACE	IN IAII							
S	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/O	utpatient 3 🗆 t	DOA X	HER: Numing Nome	5 G Reel	Idence (8 Other (Specify)						
PHYSICIAN	27. MANNER OF DEATH	28e. DATE OF INJUR (Month, Day, Year		b. TIME OF	-	JRY AT		28d. DESCRIBE HOW IN	JURY OCCUP	RED				
BY	1 Natural 5 Pending Investigation	1 Natural 5 Pending					NO							
COMPLETED	3 Suicide & Could not be determined	RY — At home, pecify)	ferm, atree	t, fectory, office			2et. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
٦	29a. CERTIFIER CERTIFYING PHYSIC													
Š	(Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner ee stated.													
	29 SIGNATURE AND TITLE OF GERTIFIER		_		T	29c. LICEN								
H	Yould E. Vo			194	25	29d. DATE SIGNED (Manth, Day, Year) ► 11/22/97								
임	30. NAME AND ADDRESS OF PERSON WHO		DEATH (ITEM 27		° P.	· mad	. ,	Wa 0.			210 - 0			
		ROBERT E. ROBY, M.D. 2211 W. ROGERS AVE BALTO, MD. 21209												
	NOV 2 5 1997	SWA DANGSON	- Mandall	2										

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 97 35607

							Cer	titicat	e of	Death			Reg. No.			
Physici		DODOMIN CONDODONO							Me			2. Dete of De Month Novemb	Day Year		Time of Death	
/Medi Exami		4a. Facility Name	la. Facility Name (If not institution, give street and number) Stella Maris									cation of Deeth				
Funeral Director		5. Social Security I	212 10 6621 10M 20F							24 Hrs. Min.	8. Date of Birt (Month, Da March 2	h y, Year) 0 1918	9. Birthplace Country)	(State or Foreig		
tel Hygiene. J other than "naturel", o	tor	10a. State Maryland	10b. County Baltim	iore	10c. C	ity, Town		cation			10d. Inside City Li 1 □ Yes 2 ☑					
	Funeral Director	10e. Street and Nu	OAK AV	.	10f. Zip Code 2 1 2 3 4						10g. Citizen of What ເ ປຽ					
	by	11. Marital Status 1 ☐ Never Mar 3 Ø Widowed	ried 2 Married	Armed Forc 1 Yes 2 If Yes, Give	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes. 2 Ø No If Yes, Give Year or Dates:			Vas Dece Yes, spe ☐ Yes			gin? (Spe , Puerto f	city Yes or No Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc. Specify: White		
	Completed	(Spe	15. Decedent's E cify only highest gr ondary (0-12)	ade completed)	cation 16a completed) College (1-4or 5+)				rk done se retire	during most d)	of workir	ng		Sb. Kind of Business/Industry		
	Be Con	17. Father's Name	(First, Middle, Las	1)	5.								Hoszhild Kohn First, Middle, Maiden Surname)			
	To							A	Madeline Kauffman ddress (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)							
			sposition Cremetion 3 [20b.	Place of cemeter	y, crem	sition (Nar	ther pla		N	Dete ovember	20c. Location	- City or Town, S		
			5 ☐ Other (Speci uneral Service Lice	**	Mo	relan		Name ar		ess of Facility		to Isqui	Memor Baltmore		1234	
ettending physician and for use es the buriel-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Carcinomatolis Due to (or as a consequenca of):														
ed by the ettending physician and detached for use es the buriel-transit	Physician	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert						ven in Pert I.			obacco use co	entribute to the	-			
s been signed 2 should be de	Completed by P										24b. Were au	utopsy findings e prior to ion of cause				
certificate he rector, pege	Ве Соп	25. Wes case refe	rred to medical							26. Place	of Death	(Check only o	-	1 ☐ Yes	2 No	
this ce al direc	2	1 Yes 25 No 27. Manner of Death 1 Netural 5 Pending		28a. Date of Injury (Month, Day Year) 28b. Time of Injury					DOA Other: 4 Nursing Ho			dome 5 ☐ Residence 6X☐Other (Specify)HOSPIC 28d. Describe how injury occurred				
uner	13			/11	28e. Place of Injury - At home, ferm, streel, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
leeth. for: After the funer	Certificati	2 Accident 3 Sulcide 4 Homicide	investigation 6 Could not to determined	28e. Place of			rm, stre	el, factor	, onice			City or Tow	vn, State)		io realizor,	
4 hours after deeth. Funeral Director: After tely filled in by the funer	edical Certification:	3 Sulcide	6 Could not be determined	28e. Place of	etc. (Speci	fy)	death	occurred estigation	at the tir	opinion, deat	f place, e	City or Tow	cause/s) and m	enner as stated. end due to the o		
Affer funer	Medical Certificati	3 Sulcide 4 Homicide 29a. Certifier (Check only	6 Could not be determined. 12 Certifying Place Medical Examples of certifying Place Countries.	building 286. Place of building hysician: To the be miner: On the basi	etc. (Speci	fy)	death	occurred estigation	at the tir	me, date and opinion, deat	f place, e	City or Tow	cause(s) end modate and place,	enner as stated. end due to the dead (Month, Day,	cause(s)	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Margaret Sue Shortt 19, /Medical November 1997 7:20 P.M 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 393 Juliet Lane Westminster Carroll 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days 1□M AFTF Months Hours Yrs. Director 58 September 12,1939 Maryland 217--34--7031 Jsuai Residance of the Maryland 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or Itama 23a or 28a-f show the Wedical Examinating the notified at 1 Yes 2 No Director Maryland | Carrol1 Westminster 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 393 Juliet Lane 21157 U.S. death Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Biack, Whita, atc. 11 Marital Status 12. Was Decedant Evar In U.S. Armed Forcas?

1 Yas 2 No
If Yas, Giva
Yaar or Datas: filed within 72 hours efter 1 ☐ Naver Married 2 🖾 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 NNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacedant's Education 16a. Decedant's Usual Occupation 16b Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT usa ratired) (Specify only highast grada complated) nd Mental Hygiene. marked other than Elemantary/Secondery (0-12) Collaga (1-4or 5+) Customer Service Manager Evapco Heating & Cooling 12th Grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked other any Injury or other traument and other 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be James Calvin Goodman Hilda Virginia Frame 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Robert G. Shortt / Husband 393 Juliet Lane, Westminster, Maryland 21157 20a. Mathod of Disposition 20b. Piaca of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Buriai 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Spacify) Meadowridge Memorial Park 11/24/97 Baltimore Maryland 22. Name end Addrass of Facility 21. Signature of Funaral Sarvice Licanses George J. Gonce Funeral Home P.A. remiroush 4001 Ritchie Highway, Baltimore, Maryland 21225 Ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is cause on each line. Approximate Intarvai Betwean Onsat and Death **Physician** BRAIN METASTASES

LUNG CANCER /Medical Immediata Causa (Final disaase or condition rasulting in deeth) Examiner Sequantially list conditions, if any, leading to immediata cause. Enter Undarlying Causa (Disaasa or Injury thet initiatad evants resulting In daath) Last physiclan Box 68760 Physician/Medical the Dua to (or as e consequance of) P.O. P Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by the 1) Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy complation of causa of daeth? page 1 ☐ Yes 2 DNO 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director; After this certification of the funeral director; It Be 25. Was casa raferred to madical 26. Piace of Death (Check only ona) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 Neturai 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba datermined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Piaca of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 D Homicida 1 Certifying Phyalcian: To the best of my knowledga, daath occurred at tha tima, date and piaca, and due to the cause(s) and menner as stated.

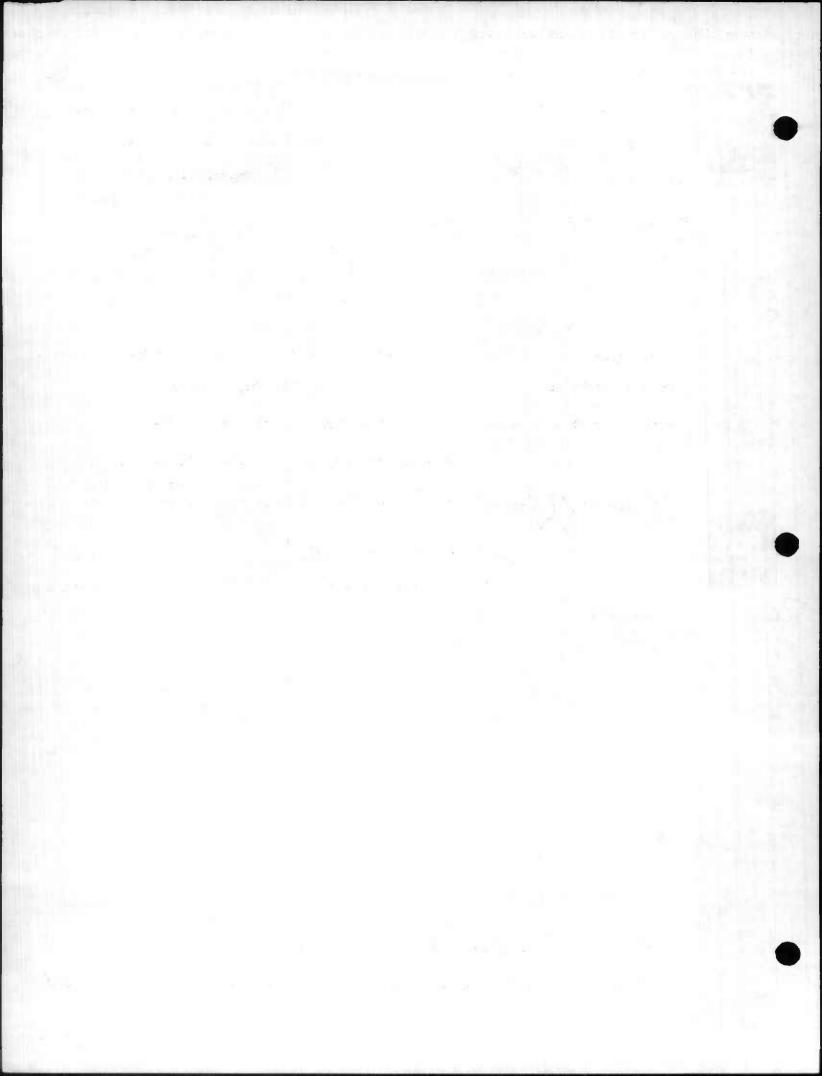
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and menner stated. Medical 29a. Cartifier (Check only 29b. Signatura end titia of certifier 29c. Licansa numbar 29d. Data signed (Month, Day, Year) D25773

State Registrar

31. Date filed (Month, Day, Yaar) NOV 2 5 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARLENE FORASTIERE 600 N, WOLFEST BALTIMORE, MD 21284 32 Registrar's Signatura Davidson-Randelle



CMK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JENNIFER SCROGGINS

State of Maryland / Department of Health and Mental Hygiene

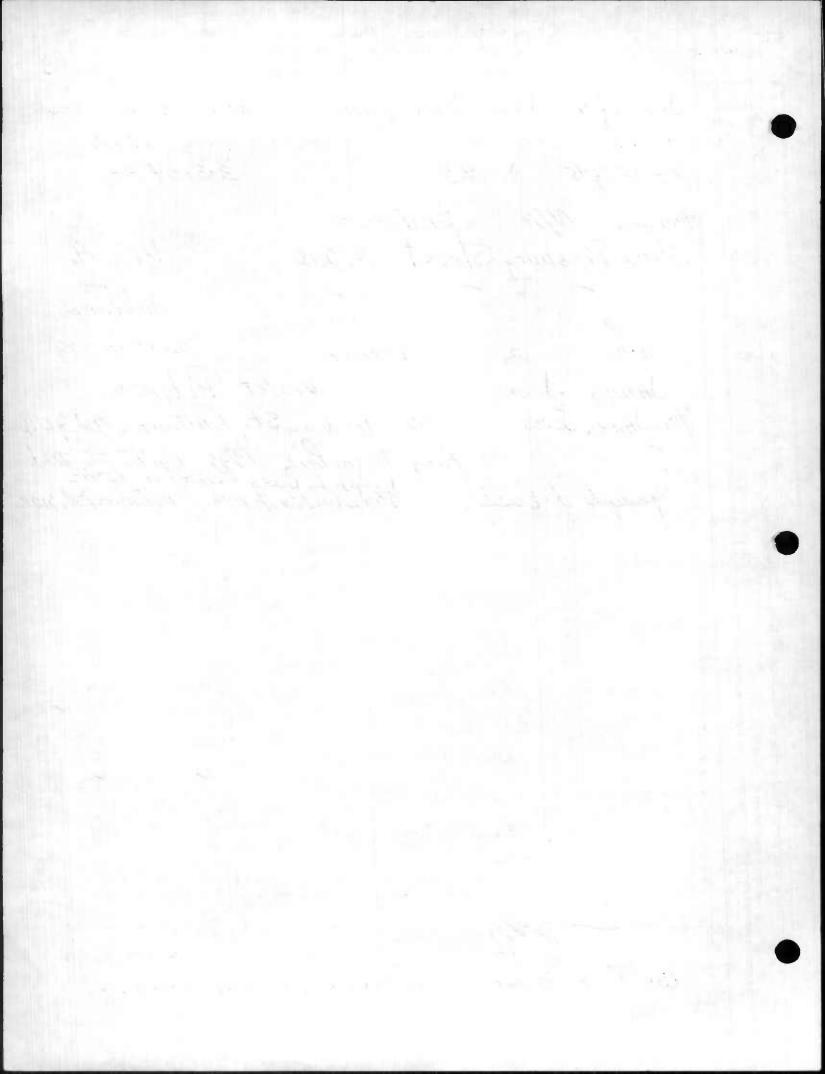
glerie	0	7	3	5	6	0	
Reg. No.	1	1	0	J	U	U	

Items: 23 part I,27,28a-f per MEO G-755 1/5/98 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Jennifer Jones 4e. Fecility Neme (If not institution, give street end number) NOVEMBER 22, 1997 /Medical 0430AM 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 4406 MARBLE HALL ROAD BALTIMORE CITY 9. Birthplace (State or Foreign Country) 5. Sociel Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Months Deys Hours 1□M 2 F 213-60-2645 Usuel Residence of Decedent Yrs. Director the Maryland 10e Stete 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner right be notified at 12 Yes 2 No Directo 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 6 3202 or items 23a Funeral death Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus d Forces? 72 hours efter 1 Never Merried 2 Married TYes 1□Yes 2₽No Baltimore, Maryland 21215-0020 Specify by 3 ☐ Widowed 4 ☐ Divorced marked other than "naturel", Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
tre: OO NOT use retired) 15. Decadent's Education 16h. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. Macker 20250 Peges 1 and 2 should be fill ent of Health end Mentel Hyt: If Item 27 is marked other y or other traumatic eventy 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Be Ames ones KO 19e. Informent's Name/Relationship (Type, Print) 20e. Method of Disposition 20b. Pleca of Dispo cemetery, cre Peges 1 1 Burial 2 Cremetion 3 Removel from Stete permit. Pege Department of Important: If any Injury or □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee uso Enter the disease, or complications that caused the death. Do not principle trailure. List only one ceuse on each line. ntervel Between Onset end Death Physician Immediate Ceuse (Finel ALCOHOL AND NARCOTIC INTOXICATION diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thei initieted events resulting in death) Last and Due to (or es e consequence of): Box 68760. physician Physician/Medical the Due to (or es e consequenca of) ettending Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Onknown Records, by 90 24b. Were autopsy findings evelleble prior to Completed 24e. Wes en eutopsy completion of cause of death? page 2 s certificate hes 19 Yes 2 \(\text{No} 15 Tes 2 No Division of Vital Attending Physicien: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1⊠Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28e. Dete of Injury found on 11/22/97 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel fourtdurat death. 1 Yes 2(X) No 2 Accident ofter death Director: 4:14 Unknown in by the Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Royle Number, City or Town, Stete) 406 Marble Hall Rd. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours of To the Funeral D completely filled is Found ar a friend's house Baltimore, Md. 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) O.C.M.E. NOVEMBER 22, 1997 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) David 111 Penn Street, Baltimore, Maryland 21201 32 Registrate Signature and M. 31. Dete filed (Month, Dey, Year) State

DHMH 16 Rev 6/95

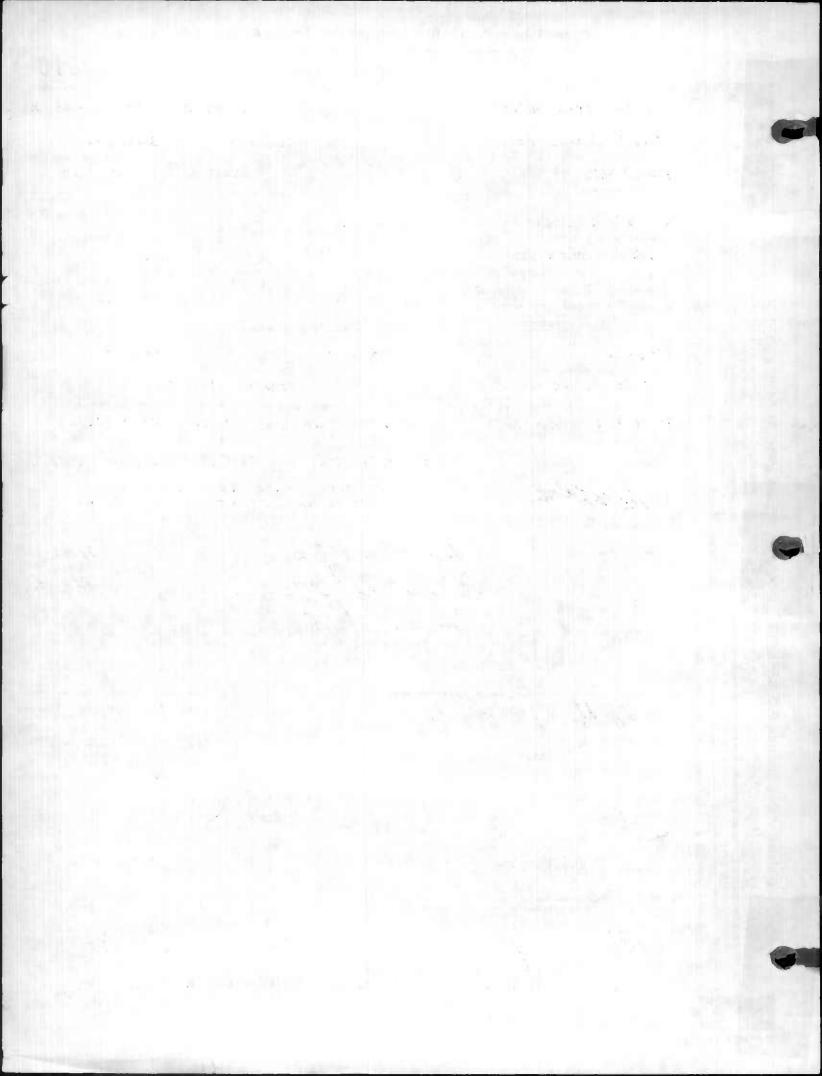
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

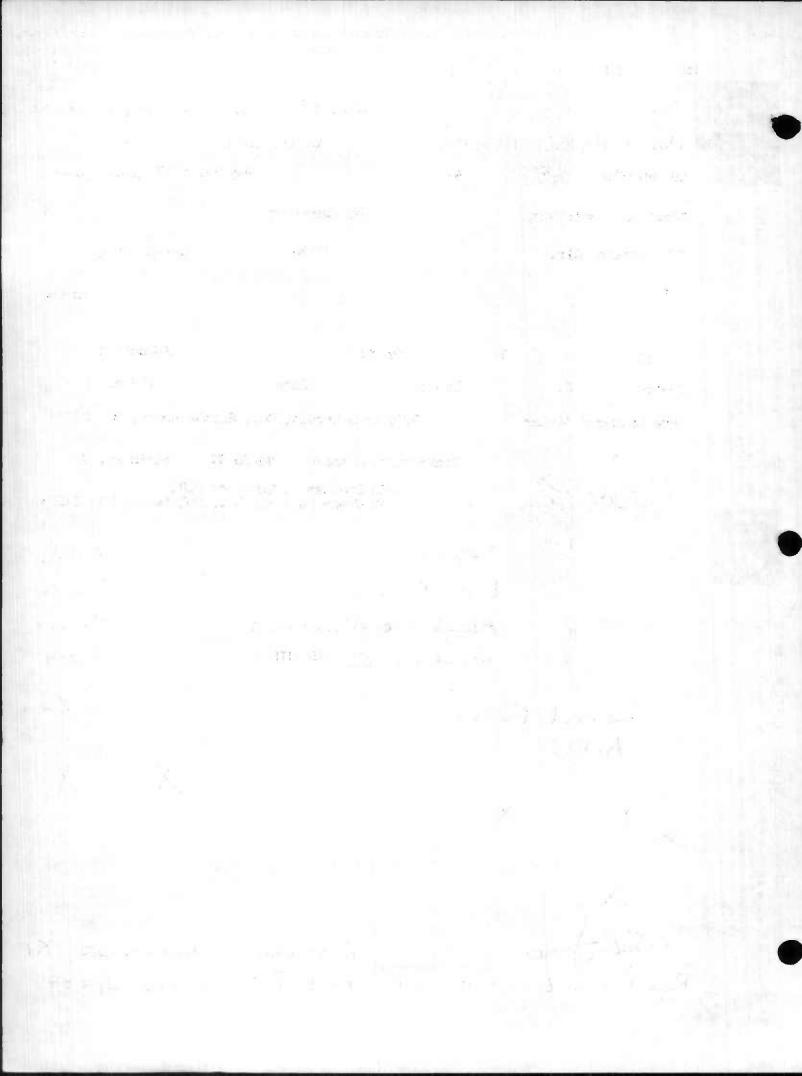
	Certificate of Death		Reg. No.	35610
Physician	1. Decedent's Name (First, Middle, Last)	2. Dete of De Month	Dev	3. Time of Death
edical	berry Ann Smein	November Location of Deeti		997 8:45 AM
niner	2608 Meadowland Court Balti			timore
al or	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	s. 8. Date of Bir	th Year) 4. 1926	9. Birthplace (State or Foreign Country) Maryland
	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ō	Maryland Baltimore Baltimore			1 ☐ Yes 2 No
Director	10e. Streel and Number 10f. Zip Code		10g. Citizen of W	hat Country?
O	2608 Meadowland Court 21234	U - 11	U.S.A.	
by Funerai		Specify Yes or No into Rican, etc.)	14. Raca Black Specify:	- American Indian, K, White, etc. White
			16b. Kind of Bus	siness/Industry
Be Completed	(Specify only highest grade completed) Elementary/Secondery (0-12) 12th grade (Give kind of work done during most of wilden. DO NOT use retired) Homemaker	orking	Own t	lome
o Be C		ame (First, Middle	, Maiden Sumame ight	a)
T	19e. Informent's Name/Reletionship (Type, Print husband) 19b. Mailing Address (Street and Number or F		9	State, Zip Code)
	Franklin G. Smith, Sr. 2608 Meadowland Ct.,			21234
5	20a. Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State
5		11/26/9	1 Baltime	ore, Maryland
DUCE.	21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Schimunek Funera 9705 Belair Rd.	al Homes.	Inc.	21236
	23a. Part1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.			Approximate Interval Between
ian cal ner	fmmediate Cause (Final disease or condition resulting in death) a. Congustre Heart failure			Weeks
	Due to (or as a consequence at):	ne		Monther
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
Medical				
Physician/M	0.			
ysic	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Dld	tobacco use con	tribute to the cause of death?
by Ph	5/ Gultiple Strokes	1 🗆	Yes 2 No	3 Probably 4 Unknown
Completed			an autopsy ormed?	24b. Were autopsy findings evailable prior to completion of cause of death?
Comp		10	Yes 200	1 Yes 2 No
Be	25. Was case referred to medical available 26. Piece of D	eeth (Check only	one)	
To To	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Other: 4 ☐ Nursing			er (Specify)
tunera tion:	27. Menner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2 Accident Investigation 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?	28d. Describe	how injury occurre	ed
led in by the tuner. Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, sfreef, factory, office building, etc. (Specify)		(Street and Number wn, State)	er or Rural Route Number,
edical C	29e. Certifier (Check only one) 29e. Medical Examiner: On the besi of my knowledge, death occurred at the time, date and placed the control of the pass of examination and/or investigation, in my opinion, death occurred the control of the pass of examination and/or investigation, in my opinion, death occurred the control of the pass of examination and/or investigation, in my opinion, death occurred the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and placed the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and placed the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and placed the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and placed the control of the pass of examination and/or investigation, in my opinion, death occurred at the control of the pass of examination and/or investigation, in my opinion, death occurred at the control of the pass of examination and/or investigation, in my opinion, death occurred at the control of the pass of examination and/or investigation, in my opinion, death occurred at the control of the pass of examination and occurred at the control of the pass of examination and occurred at the control of the pass of examination and occurred at the control of the pass of examination and occurred at the control of the pass of examination and occurred at the control of the pass of examination and occurred at the control occurred at t			
Med	29b. Signature and bits of certifier 29c. License number		29d. Date signed	i (Month, Dey, Year)
ō	Nausence Mplly 1/2 12809	7	11/24	/97
	30. Name and address of person who completed cause order (Item 23a) (Type, Print) Lawrence Mills Jr. Lord Samaritan Holpit	zl 5601	Loch Ras	en Blok, 10, md 21239
State egistrar	31. Date filed (Month, Dey, Year) NOV 2. 5 1997 Sund June doon - hands le		Ba	lto, md 21239

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q Item: 23 part I, per Physician G-756 2/12/98 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Edward November 23, 1993 2020 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmone Itospital Johns Hopkins If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Days Hours Min. | May 24, 1953 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiaca (State or Foreign Country) **Funeral** 1 € M 2 □ F Yrs. Director 193 46 6092 Pennsylvania 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits mest be notified at Reisterstown Maryland Baltimore 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? filed within 72 hours after death with 21136 169 Shetland Cir. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 [X]No tf Yas, Giva Yaer or Datas: Raca - American Indian, Black, White, atc. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 7 is marked other than "natural", or item traumatic event, the Medical Examiner 1 Navar Married 2 Married 21215-0020 White 1 ☐ Yas 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Education Teacher 5+ 12 Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic evant 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Spotts 0. Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 9969 Lake Landing Rd., Gaithersburg, MD Jame Wilder / Sister 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a, Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burlat 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 11/26/97 Baltimore, MD 22. Nama and Addrass of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 Collemann 23a. Part1. Ental the disease, or complications that caused the death. Do not anter the mode of dying, such as cardlec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner to (or as a consequence of): 1-adur Sequentially list conditions, if any, laeding to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Lest Dua to (or as a consequence of) 68760 8 Physician/Medicai 84 Dua to (or as a consequance of): HEPATITIS B Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 4 Unknown 1 ☐ Yss 2 ☐ No 3 Probably of Vital Records, 24b. Wara autopsy findings available prior to completion of cause Completed 24a. Was an autopsy performed? The law of death? 2 No Be 25. Was casa rafarred to medical examinar? 26. Placa of Daath (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 70 Inpatiant 2 ER/Outpatient 3 DOA Tige State 27. Manger of Deat Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Athur Division Attending Naturel 5 Pending Invastigation 1 Yes 2 No 2 Accidant after death 6 Could not be 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) B 4 Homicide 6 To the Hospital within 24 hours a To the Funeral Hospital Certifying Physictan: To the best of my knowledge, deeth occurred at tha time, dete and plece, and dua to the causa(s) and menner es stated.

2 detection of the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated. Medical (Check only 29b. Signature and title of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name and address of person who complated causa of death (Item 23e) (Type, Print) Street Baltmore, MD 2/287 600 North Wolf 32, Ragietrar's Signatura State Davidson-Randolo Registrar



97-6724-005 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. CMK State of Maryland / Department of Health and Mental Hygiene Q CHARLES G. SELLERS, III Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month NOVEMBER 21, 1997 **Physician** 0032AM Charles Griffith Sollers III /Medical 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner BALTIMORE COUNTY ROUTE 30 AND LEE'S MILL ROAD BORING 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Dec 29 6. Sax **Funeral** Birthplace (State or Foreign
Country) DEM 2□ F Months Days Hours Min 35 Yrs. Director 100-54-3644 1961 Maryland Usuai Residence of Decedent Maryland ta or 28a-f show 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits Director 1 Yes 2 No MD Frederick Frederick the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must 9196 Lansing Court 21701 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 反 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced White 'neturel', Completed The Medical 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) I Hygiene. Eiementary/Secondary (0-12) Coilege (1-4or 5+) Service Advisor Automotive Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be nent of Health end Mental 27 is marked or treumatic ever Charles Griffith Sollers Jr. 2 Shirley Jean Sprandel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) of Health of Item 27 | Laurie Everett/Sister 3304 Niles Street, Silver Spring, MD 20906 other 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removel from State 士占 Department of Important: If any injury or once. Hillcrest Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 11/24 Annapolis, MD 21 Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave., Annapolis, MD e feath. Do not enter the mode of dying, such as cerdiac or respiratory arrest, 21401 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Physician Immediate Ceuse (Final MUINEL INUME disease or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Diseesa or injury that Initiated events resulting in deeth) Last Due to (or as e consequence of): exe eq Physician/Medical the Due to (or as a consequence of) se esn Box The law requires that the death P.O. Part II. Other aignificant conditiona contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 99 page 2 should Completed 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Was an eutopsy performed? 1 Yes 1 Yas 2 No of Vital Physician: 25. Was case referred to medical Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? WITH ACAR il or Attending P s efter deeth. I Director: After i Division 1 Natural
2 Accident 5 Pending Investigation Injury 2305 M DRIVER OF CARIN WUSSIN 20 97 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 | Homicide DOD WAY RT30+LEE'S HILL RD BANMONS-CON Hospital 24 hours 29a Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and piace, and due to the ceuse(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signal re end title of certifier 29c. License number 29d. Data signad (Month, Dey, Year)

8

State 31. Date filed (A

HAMPOUTD D. KONEW
31. Date filed (Month, Dey, Year)
32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201
32. Registrar's Signature

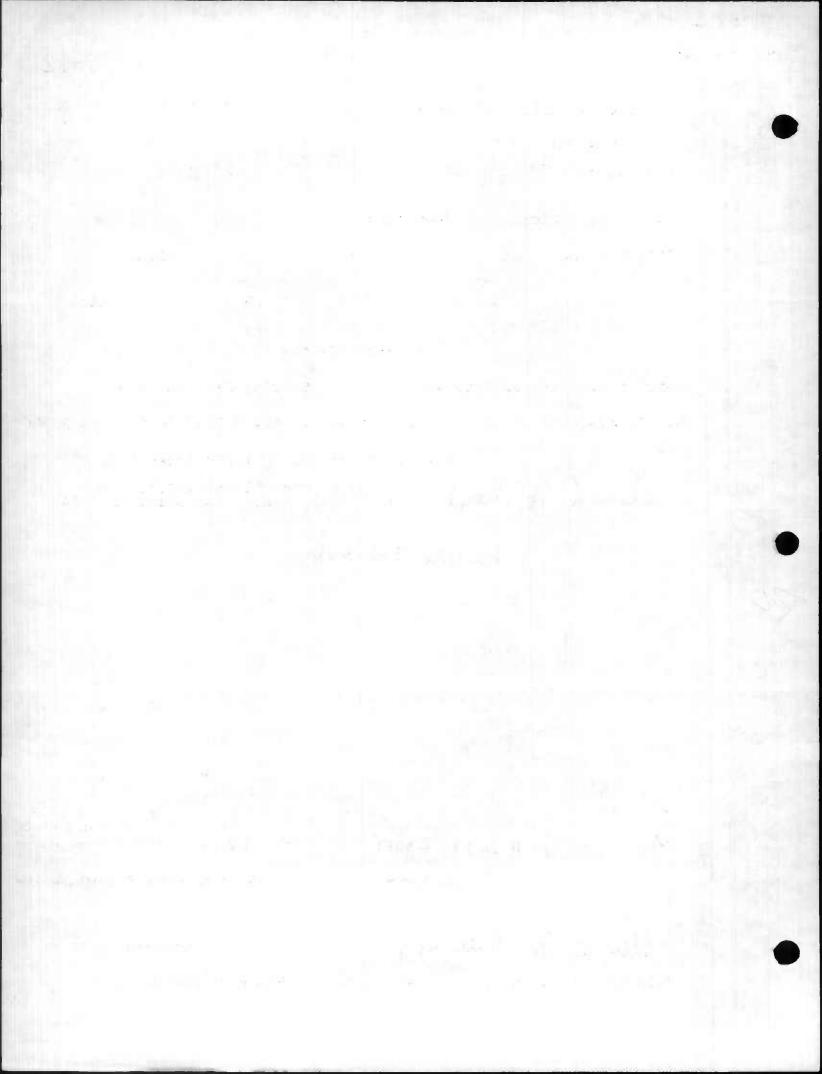
Juna Davidson Fundall

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O.C.M.E.

NOVEMBER 21, 1997

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Voer 1330 Km November 1997 ALBERT M. SHILINSKI 4a. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BAITTMORE
If Undar 1 Year If Under 24 Hrs. 8. Date of
Months Deys Hours Min 8. SAINT AGNES HOSPITAL 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 10M 2□ F 213-07-0450 Usual Residence of Decedent 84 JUN. 6, 1913 MARYLAND 10a. Stele 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes ZENo MARYLAND BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1914 ALTAVUE ROAD 21228 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 20 No If Yes, Give 14. Race - Amarican Indien, Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Stetus Bleck, White, etc. 1 Never Marriad 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OWNER GROCERY STORE 12 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) BARTHOLOMEW SHILINSKI ANNA PRAEBIS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 925 RYERCROFT COURT, SEVERNA PARK, MD 21146 RAY SHILINSKI, SON 20b. Place of Disposition (Nema of cemetary, crametory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Data 1 XBuriel 2 ☐ Cremation 3 ☐ Ramoval from State 4 □ Donation 5 □ Other (Specify) MEADOWRIDGE MEMORIAL PARK11/21/97 DORSEY, MARYLAND 22. Name end Address of Fecility WITZKE FUNERAL HOMES, INC. 21. Signature of Purieral Service Licensee 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23e. Pert1. Enter the disease, or complications that causad the death. Do not entar tha mode of dying, such as cerdiec or respiratory errest, shock, or heart feiture. List only ona cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) Due to (or as a consequence of) Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 No 3 Probably 4 Unknown numme 24b. Were autopsy findings eveileble prior to completion of causa of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 26. Place of Death (Check only ona)

Physician /Medical Examiner

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signed d be det

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Completed

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Medical Certification: To

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Med cal Examinal must be notified at

permit. Peges 1 and 2 should be filed within 7 Department of Health end Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event. In Mental Mental Count. In Mental Count.

the Marylend

Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medicai

> 25. Wes case referred to medical exeminer? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA

27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation

1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

024356

Nov 20, 1997

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and time of certifier 29d. Dala signed (Month, Dey, Year) 29c. License number

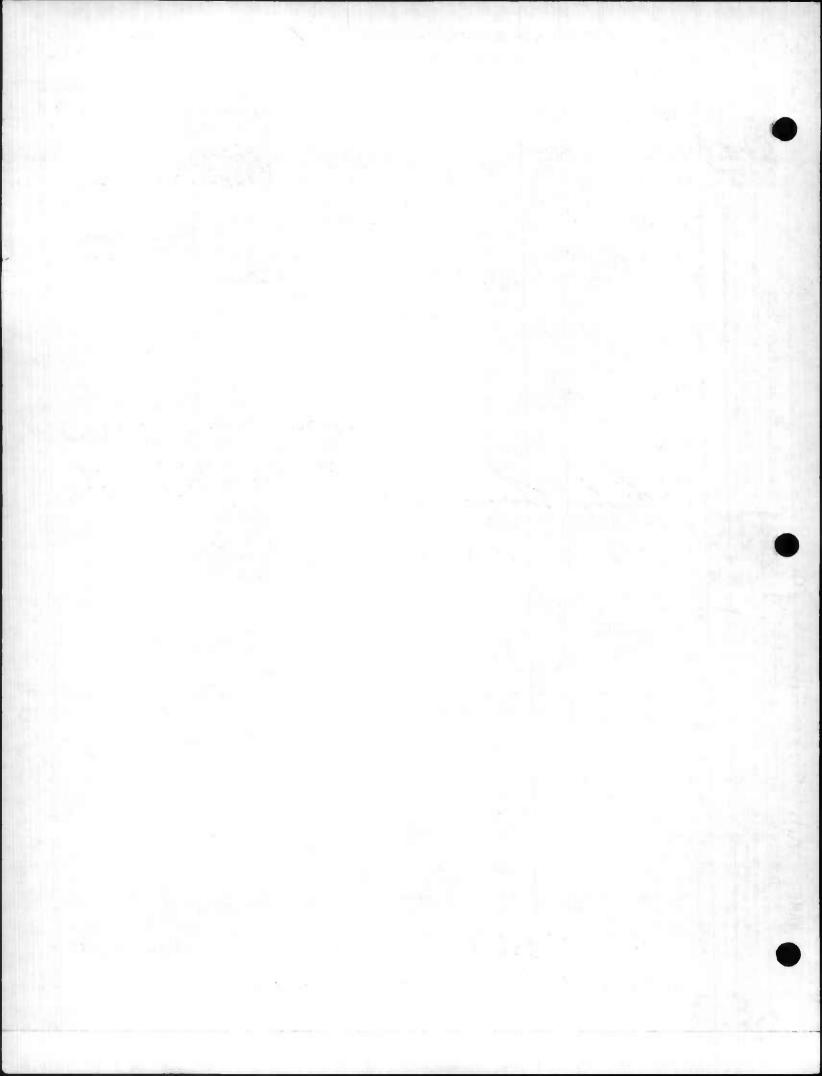
30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Balton M/ 21229 St Agnes Health Care 900 Caton toe 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year)

State Registrar

To the Funeral

To the Ho within 24 t



State of Maryland / Department of Health and Mental Hygiene

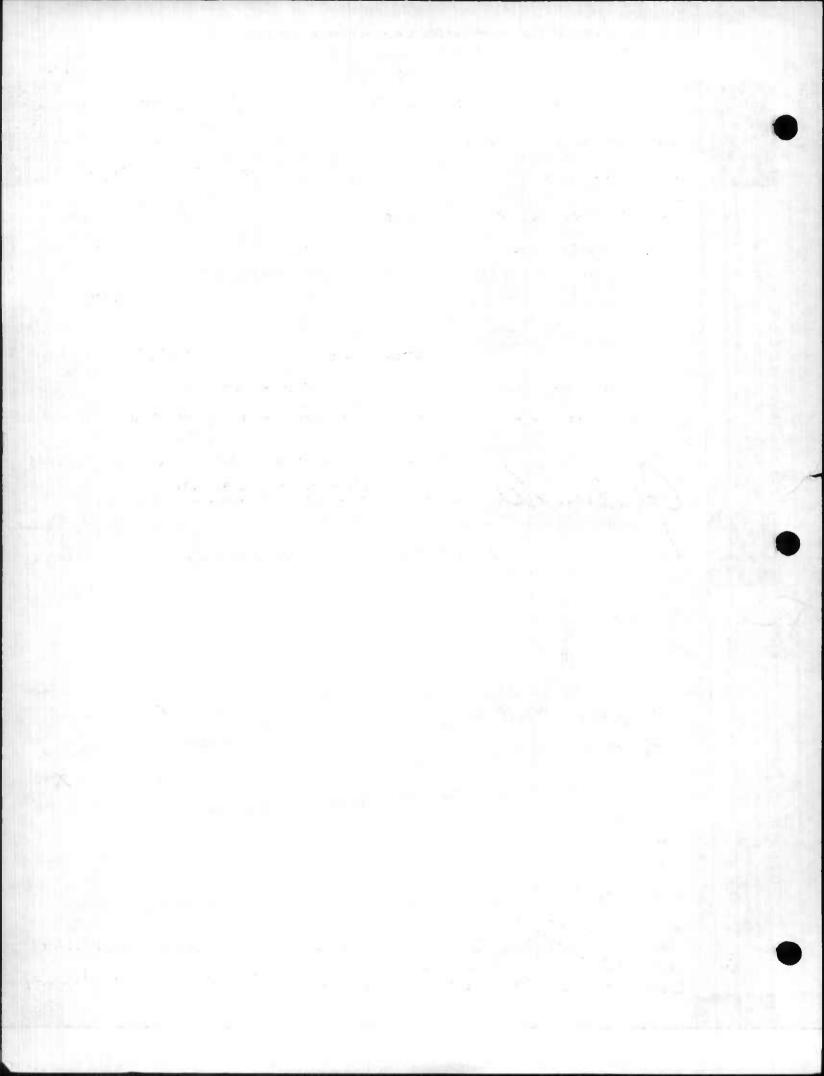
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iner	4	a. Facility Nema (If not institution, give Montgomery Gener					4b. City, Town, or L Olney	ocation of Deeth			County
		6. Sociel Security Number 6. Security Number 213-01-6975	-	7. Aga (In yrs. I	last birthday) Yrs.	If Under 1 Yaar Months Days		8. Date of Birt (Month, De July 25			eca (Stata or Foreign
1		Usuel Residence of Decedent 10a. Steta 10b. County		10c. City	y, Town or Lo	cation				10	d. Inside City Limits
tor		Maryland Howard	County		Lau	rel					1 Yas 20 No
Funeral Director	1	0e. Street end Number 10461. Scaggsville	Road			10f. Zip Coda	20723		10g. Citizen of		ry? SA
		1. Marital Status 1. Never Merried 2. Merried XXWidowed 4. Divorced	Armed For 1 Tayas If Yes, Give		1	Was Dacedant of I f Yes, specify Cub I ☐ Yes 2 ☐XNo	Hispanic Orlgin? (Sp an, Maxicen, Puarto Specify:	ecity Yas or No- Ricen, etc.)		ce - America ck, Whita, a y: Whit	itc.
eted		15. Decedent's Ed (Specify only highast grad	ucetion de completed)		16e. Deced	tent's Usuei Occur kind of work done	petion during most of work id)	ing	16b. Kind of B	usiness/Ind	ustry
Completed by		Elementary/Secondery (0-12)	College (1-	-4or 5+)		k driver	(d)		freigh	+ line	95
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To	L	Daniel Lee			·		Nettie				
		19e. Informent's Neme/Relationship (T Ir. Michael Sowers					Road, Bal				
١,	-	Oe. Method of Disposition		20b. Pi	lece of Dispo	sition (Neme of		Dete	20c. Location		
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	-	21. Signature of Funeral Service Licens	Ses	M005			Funeral ott City,			2	
				,				or respiretory er			Approximate intervat Between Onset end Deeth
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Via Davidson-Randelle

DHMH 16 Rev 6/95

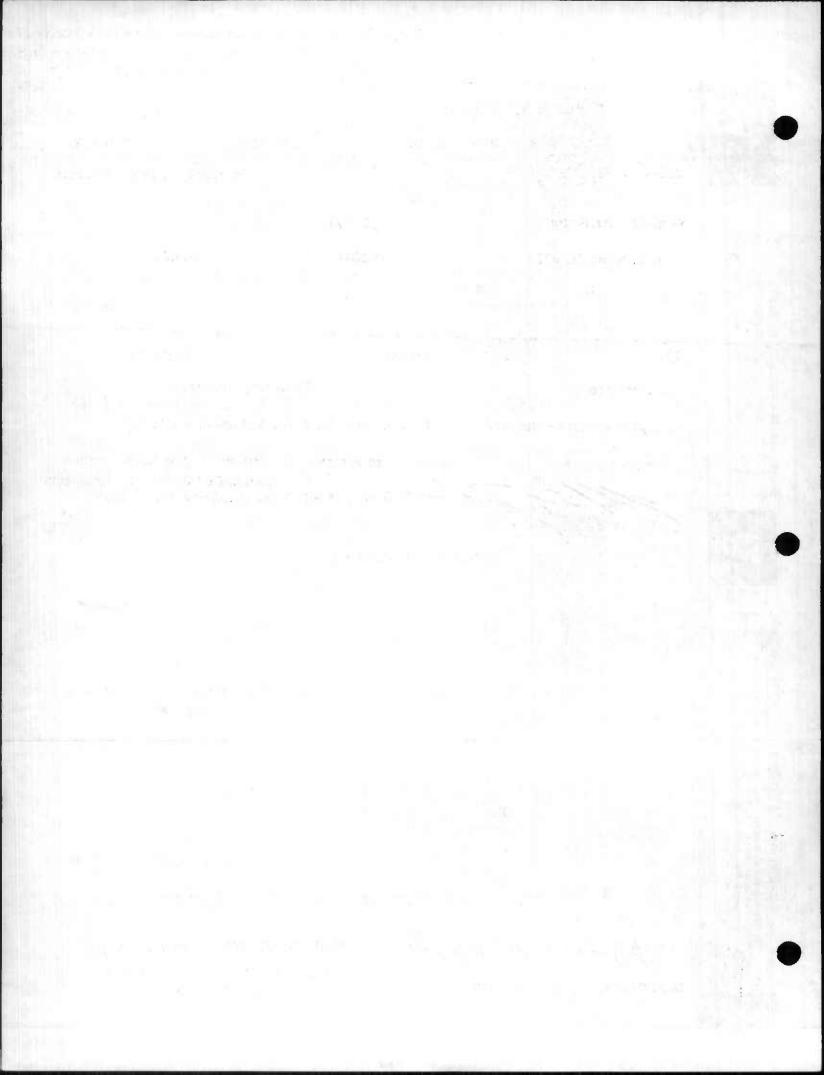
Registrar

NOV 2 5 1997



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death Day Month **Physician** TAMMIE R. SEYMORE OCT 24 1997 7:00 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY H Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Day, Yaar) Pebruary 25, 1959 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** 1 □ M 2 TF 253-11-7671 Director 38 Georgia Usual Rasidance of Dacedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "natural", or items 23a or 28s-4 show other traumatic event, the Modical Examinar insist be notified at 1 ☐ Yas 2 🕅 No Director Virginia Arlington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 22204 1301 S. Scott St. #724 death Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 72 hours after I ☐ Yas 2 💆 No If Yas, Giva Yaar or Datas: 1 Never Marriad 210 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: à 3 Widowed 4 Divorced Black Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiens important: if item 27 is marked other than nery injury or other traumatic access Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Owner Day Care 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Flora May Holloway 2 M.C. Prothro 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1301 S. Scott St. #724, Arlington, VA 22204 Kenneth Seymore - Husband 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Buriai 2 Cramation 3 Ramoval from Stata 10/29/97 Dale City, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) Potomac Crematory 21. Signature of Funarai Sarvice Licensae 22. Name and Address of Facility A Dignified Funeral & Cremation Service, 18401 Cedar Dr., Triangle, VA 22172 2 Part1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onsat and Death **Physiclan** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) HEPATO-RENAL SYNDROME Examiner Dua to (or as a consequanca of). Physiclan/Medical Examiner Saquantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Lest Dua to (or as a consequence of): Dua to (or as a consequence of): Box Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.0. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wara autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? Completed peen page 2 1 ☐ Yas 2 No certificata 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: Be 25. Was casa rafarrad to medical 26. Placa of Daath (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 ☐ Yas 2 🖾 No Medical Certification: To 1X Inpatiant 2 □ ER/Outpatient 3 □ DOA this 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Division Affer 5 Panding invastigation 1 Matural death. 1 ☐ Yas 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicida To une within 24 hours after vithe Funeral Dir 12 Cartifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 29a. Cartifiar 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 0101-051231 (VA) 30. Nama and addrass of person who complated causa of daat little 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER D.R.DEKERATRY, LT, MC, USN BETHESDA MD 20889-5600 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State Davidson-Randall Registrar



State of Maryland / Department of Health and Mental Hygiene 35616 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month **Physician** SPENCER MARIE 1997 2:40 AM MELEN November /Medical 4e. Fecility Neme (If not Institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Death OF MARY LAWS MEDICAL System BALTSMOKES

S. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day Year)

Months Days Hours Min. Jan. 5, 1945 Examiner Baltimore City UNIVERSITY 5. Social Security Number Birthplace (Steta or Foreign Country) **Funeral** 213-44-9531 Director Maryland Usual Residenca of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Marylar nent of Healih and Mertel Hygiene. Interfer them 23a or 28a-f shownit: If term 27 Is marked other than "natural; or items 23a or 28a-f show any or other traumetic event, the Medical Examples presented. Belair Maryland Harford 1 ☐ Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 113 Regent Drive USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Raca - American Indian, 11. Maritel Stetus Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes ŽÍŽNo Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highest grada complated) 16b. Kind of Business/Industry Medical Research Elementery/Secondery (0-12) College (1-4or 5+) for V. A. Administative Secretary 12th grade 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) o Milford Sheridan Brown Frances Travers Singleton 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 113 Regent Drive Belair, Maryland 21014 Mr. Kenneth E. Spencer 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 KIX remation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or Metro Crematory, Inc. 11-8-1997 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
E. F. Lassahn Funeral Home 21. Signeture of Funeral Service Licansee 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, App shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Final Due to (or es a consequence of):

of the Liver disease or condition resulting In death) Examiner Graft versus Host DisezzeAStatus post Allogenic Stemcell physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Box 68760 Blech c Gastrointestinal Physician/Medical Due to (or as a consequence of) ettending P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by the page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed 1 Yas 20 No 2 No 1 Yes certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: After Attending 5 Pending Investigation 1 Waturai To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined Location (Street and Number or Rural Route Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) November 7,1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MO 2 1201 Lathy Hernandez Greene Street 22 S. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State who Newidson NOV 2 5 1997

DHMH 16 Rev 6/95

Registrar

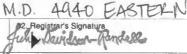
of regularity and the property of the contract of the contract

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3561 Certificate of Death 1. Decedant's Nama (First Middle Last) 2. Data of Death 3. Time of Death Day **Physician** Month enrietta Sanders :20AM November 21 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Johns Hopkins Bayview Medical Center n/a Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Aug. 18, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1□M 200 F Yrs Director 73 245-24-9902 Georgia Usual Rasidance of Dacedani the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yas 2€ No Md. Baltimore Middle River 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8 28 Left Aileron Drive 21220 USA Нети 23а Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Race - Amarican Indian, Biack, Whita, etc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) filed within 72 hours efter 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 21215-0020 ò 1 Yas 2 No Specify: White by 3℃ Widowed 4 Divorced Specify: "natural". Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry nd Mental Hygiene. marked other than Eiamantary/Secondary (0-12) Coliega (1-4or 5+) Clerk Mote1 12th Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) . Pages 1 and 2 should be fill transfer of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Hubert Wilson Bunia 19e. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) Franklin Sanders Jr./son 28 Left Aileron Drive Baltimore Md. 21220 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete ▶ Burial 2 □ Cremetion 3 □ Ramoval from State permit. Page Department of Important: If any Injury or once. Parkwood Cemetery 11/24/97 Baltimore Md. 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funarai Sarvica Licansea 22. Nama end Addrass of Facility Connelly Funeral Home of Essex lisations that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast ne cause on each line. 300 Mace Ave. Baltimore Md. 21221 23a. Part1. Entar tha disaasa, or com shock, or haart failure. List only **Physiclan** /Medical Immediate Causa (Final Cancer 2 months una disaasa or condition rasulting in death) **Examiner** Doa to (or as a consequence of): Examiner ician end buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Causa (Disaasa or Injury that Initiated avants resulting In daath) Last Dua to (or as a consequence of): Box 68760. physician Physician/Medical the Dua to (or as a consequence of): for use es 98 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown signed be det Records, Completed by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? pege 2 this certificate 1 ☐ Yas 2 🗙 No 1 Yas 20 No Division of Vital Hospital or Attending Physician: Be 25. Was casa rafarrad to medical 28. Placa of Death (Chack only ona) Hospital: 10 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 M Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral Certification: 27. Mannar of Death 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Neturai 5 Panding deeth. investigation 1 Yas 2 No 2 Accidant 24 hours efter deet Funeral Director: 6 Could not be dataminad 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Piece of Injury - At home, farm, straat, factory, office building, atc. (Spacify) in by 4 Homloida 29a, Cartifian Medical 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29b. Signature and titia of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) November 21, 1997

State Registrar

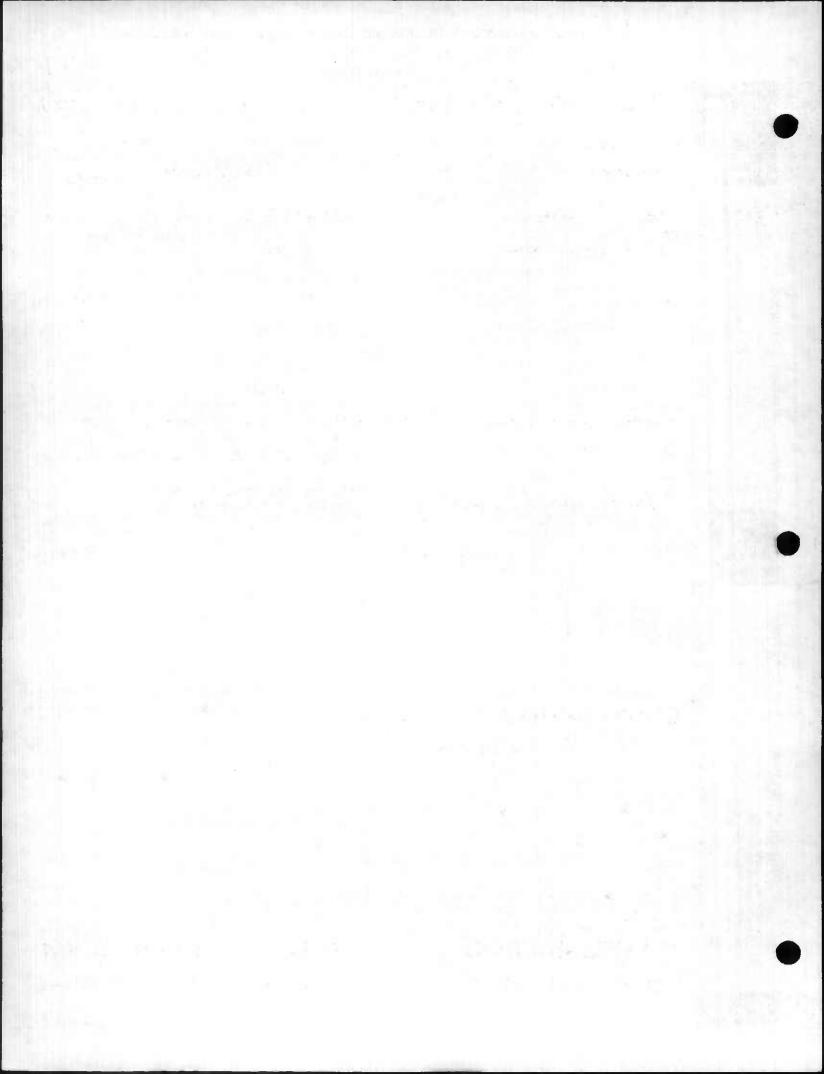
31. Data filed (Month, Day, Yaar) NOV 2 5 1997

VICTORIA PORTER



30. Nama and addrass of person who complated cause of death (itam 23a) (Type, Print)

BALTIMORE MARYLAND 21224



State of Maryland / Department of Health and Mental Hygiene Q

						Cei	rtifica	ile or	Dealli		Reg. No.		
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Funeral Director		5. Sociel Securit 131–09–6 Usuai Residence	819	6. Sex 1□ M X □ F	7. Age (In yr. 78	s. lest birthday) Yrs.	If Unda Months	ar 1 Yaar Deys	If Undar 24 H Hours M		ley, Year)	Cou	placa (Stata or Foreigntry) York City
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72 hours ener death with the Maryland hatural', or Nems 23a or 28a-f ehow dical Examiner must be nothed at	by Funeral		s arried 2□ Marrie d 4□ Divorced	Armed F	2⊉No iive		Was Dece If Yes, spe 1□ Yes	37	lispenic Origin? an, Mexicen, Pu Specify:	(Specify Yas or N erto Ricen, etc.)		ce - Americk, White, by: Whi	
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- 7 5 5		20e. Method of D	Disposition			Place of Dispo	sition (Ne	eme of		Dete	20c. Location		
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BEATRIZ P. DIZON, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Dete filed (Month, Dey, Yeer)

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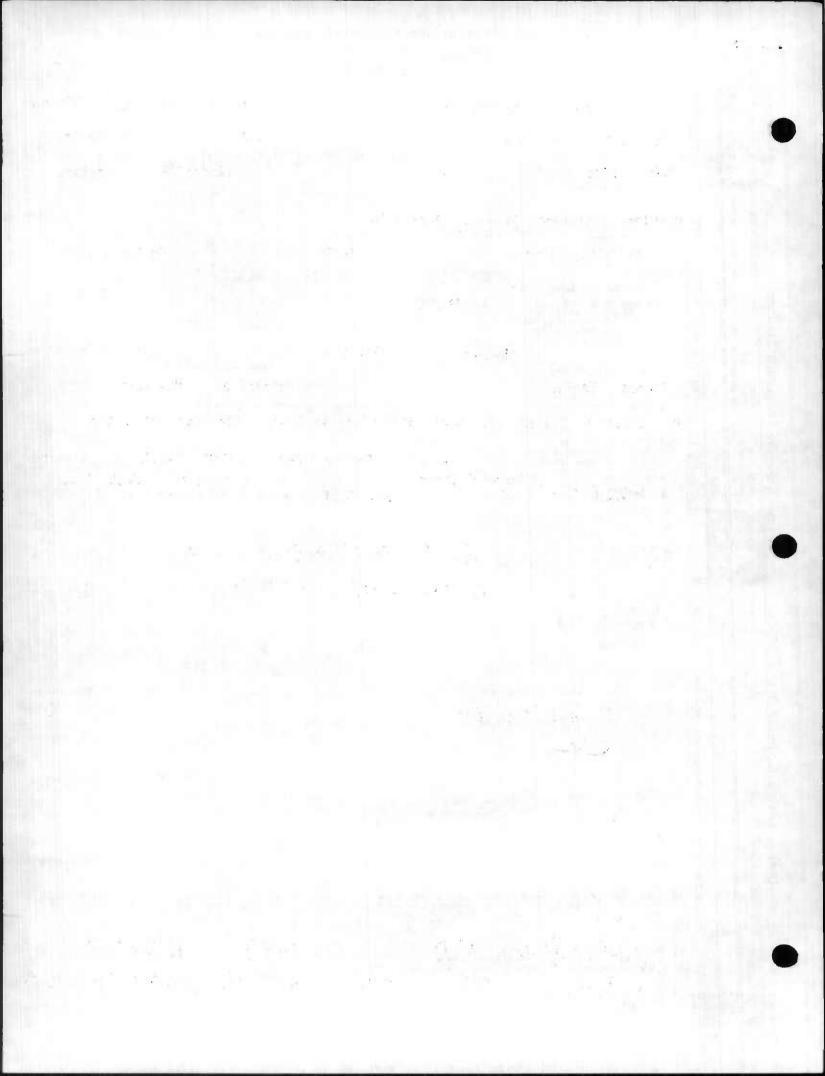
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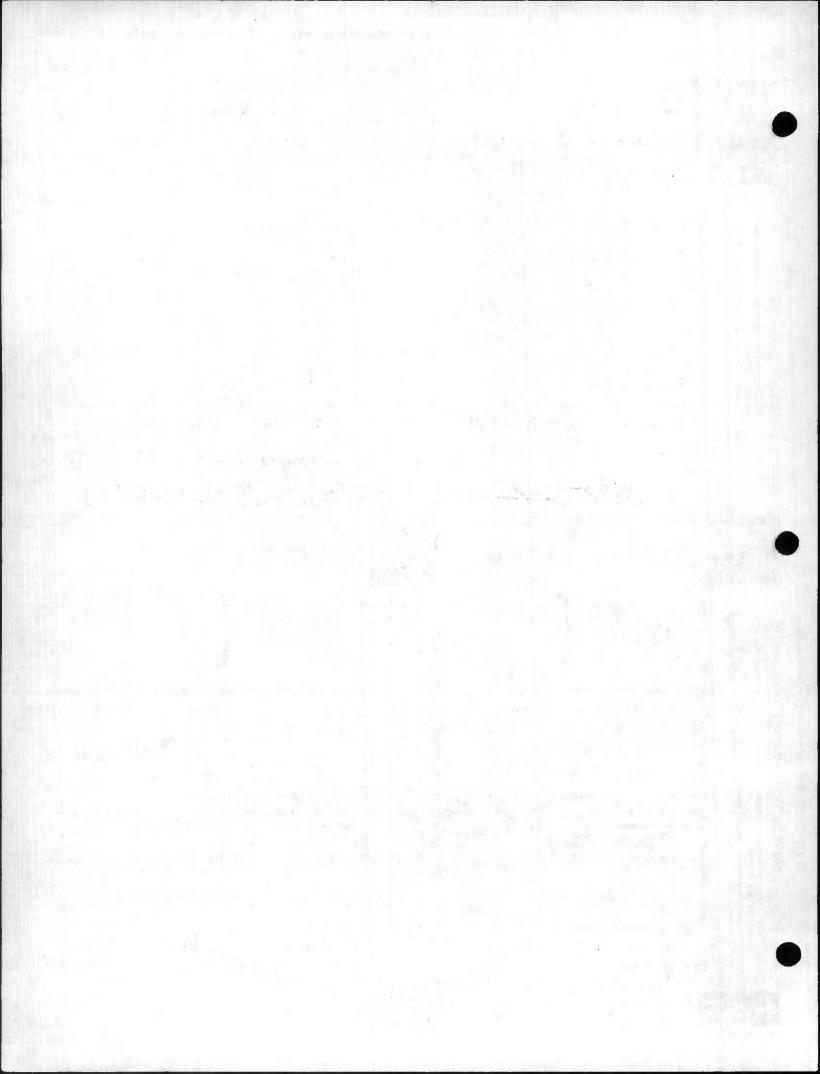
State of Maryland / Department of Health and Mental Hygiene 7 356 19

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xaminer	4a Facility Name (If no							r Location of Death		
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be notified Director	10e. Street and Numbe		C 001	1 4		10f. Zip C	ode		10g. Citizen of Wi	hat Country?
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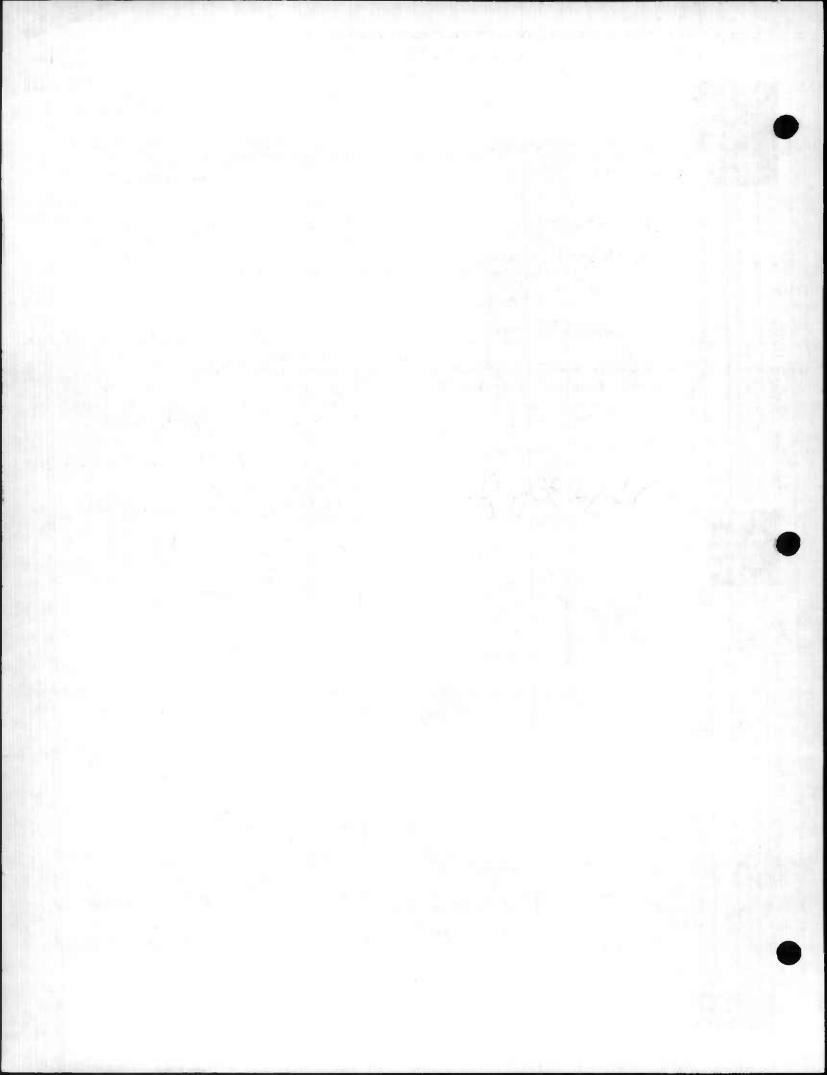
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dhuala	ian.	1. Decedant's Nama (First, Midd	dia, Last)	HIND IN					2. Data of De	Reg. No.	3. Time of Deat
Physic /Medi		MARY L. TSCHUD	У						Noveme	ER 19 1	997 7 40 997 7 Pm
Exami		4e. Fecility Nema (If not institution						4b. City, Town, or		h 4c. County	of Death
	Ш	Fallston Gener						Fallston		Harf	
Funeral Director		5. Social Security Number 213-32-2782 Usual Rasidance of Dacadant	6. Sax 1 □ M 2 ☑ F	7. Aga (In yrs. 64	lest birthday) Yrs.	If Unde Months	Days	If Undar 24 Hrs Hours Min.		4, 1933	9. Birthplaca (Stata or Fore Country) Maryland
yland		10a. Stata 10b. Count	у	10c. Ci	ty, Town or Lo	cation					10d. Insida City Lim
Mar	tor	Maryland Harf	ord	Jo	рра						1 ☐ Yas 2 🗖
th the	irec	10e, Street end Number				10f. Zip	Coda			10g. Citizan of W	Vhat Country?
th will	aic	2410 Kingsbury	Drive			21	085			U.S.A.	
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentali Hygiene. Timportant: If fire 72 is marked other than "nature!, or Items 23s or 28s-f show any injury or other traumatic avent, Ite Modical Example must be notified at page.	by Funeral Director	11. Marital Status 1 Navar Marriad 2 Ma 3 Widowed 4 Divorce	If Yas Give	2 🔯 No				dispanic Origin? (S an, Maxican, Puan Specify:	pecify Yas or No to Rican, etc.)	14. Race Blec Specify.	e - American Indien, k, Whita, atc. : White
72 ho	ted	15. Deceda	nt's Education ast grada complated)		16a. Deced	ant's Usu	al Occup	eation during most of world)	rklan	16b. Kind of Bu	sinass/Industry
bermit. Pages 1 and 2 should be filed within 72 hours eft begannent of Health end Mental Hygient and Intervent. If item 27 is marked other than "naturel", or my injury or other traumatic avent, the Medical Examinate.	To Be Completed	Elementary/Secondary (0-12)		4or 5+)	Homen			d)	iking	Own H	ame.
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alth alth 27 is		Edward C. Tsch	udy (Husba	nd)	2410	Kin	gsbu	ry Drive	, Joppe	a. MD.	21085
of He item		20a. Mathod of Disposition	- 7-	20b. F	Place of Dispos cematery, cram	sition (Name	na of othar place	ce)	Data	20c. Location -	City or Town, Stete
Page int: If		1 Burial 2 ☐ Crametion 4 ☐ Donetlon 5 ☐ Othar (S							11/22/97	Falls	ton, Maryland
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Physician /Medical Examiner	er	Immadiata Ceusa (Final disaasa or condition rasulting In daath)	a br		Tempor as a consagu		to	ke.			Onsat end Death
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	rtfle	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicida datam	nined 20a. Place	of Injury - At he g, atc. (Specif	oma, farm, stre	at, fectory	, office		28f. Location (City or To		er or Rural Routa Number,
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State of Maryland / Department of Health and Mental Hygiene 9 7 3562

				Certific	ate of	f Death	Re	g. No.	0	004	
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		236 North Caroli				Pasadena			nne /	Arundel	
Funeral Director		5. Social Sacurity Number 8. Sec. 214-42-1522	7. Age (In yrs	Yrs.	hs Deys	or If Under 24 Hrs. S Hours Min.	8. Dete of Birth (Month, Dey, Jan. 25	Year) , 1945	Cour	elece (Stete or Fore try) Vland	əign
pu *		Usuel Residence of Decedent 10e. Steta 10b. County	100 0	ity, Town or Location							
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the A	ect	Maryland Anne Ar	undel	106	Zip Code	adena	11	og. Citizen of V	What Cour		
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other		20e. Method of Disposition	20b.	Place of Disposition (cemetery, cremetory	Neme of	lace)	Dete 2	20c. Location -	City or To	wn, Stete	
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C 2 2 2	ion	27. Menner of Déeth 1	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inje	ury et 2 ork? □ Yes 2 □ No	8d. Describe hor	w Injury occurr	ed		
Division O Attending site deam. Director After J in by the fune	lical	Accident Investigation 3 Sulcide 6 Could not be	28e Place of Injury - At h				8f. Location (Str	eet and Numh	er or Rura	I Poute Number	
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Divisio To the Hospital or Attendit within 24 hours after death. To the Funeral Director A completely filled in by the fu	edical C	29a. Certifier (Check only one) Cartifying Phy	sician: To the best of my kno ner: On the basis of exemine end menner steted.	owledge, deeth occurrention end/or investige	ed et the tion, in my	time, dete end piece, er opinion, deeth occurre	nd due to the ce d et the time, de	use(s) and ma te end piece,	nner es si end due to	ated. tha cause(s)	
To th To th comp	Me	29b. Signature end title of certifier	1		29c. Licer	nsa number	29	d. Dete signad	(Month,	Day, Year)	
		branda	Sorbak	2/110	0	2793 F	N	lovembe	r 25,	1997	
		30. Name and eddress of person who c	ompleted cause of death (IIII	1 23e) (Type, Print)	•						
		Dr. Maywe Gorba		hart Rd. 0	alen	Burnie, Md.	21060				
Sta		31. Date filed (Month, Dey, Year)	32. Registrar's Story	ature		,,					Broken op
Registr	ar	NOV 251	997 general	Swidson-Mand	Mariento.	30					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3:20 PM November , 1997 Noah Leslie Trowbridge 20 4e. Facility Name (If not institution, give straet and number) 4b. City, Town, or Location of Death 4c. County of Deeth N / A Baltimore | Baltimore Union Memorial Hospital 5. Sociel Sacurity Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) July 25, 1932 8. Birthplaca (State or Foraign Country) West Virginia 1X) M 2□ F Months Days Hours 65 Yrs. 236-56-1936 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 XYes 2 No 10a. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? 508 Cathedral Street 21201 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yas, Give 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 X Naver Married 2 ☐ Marriad 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Yaar or Detas: WW2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12th Maryland Cup College (1-4or 5+) Machinist Company 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) William H. Trowbridge Emmie Wagner 19e. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 225 Hartman Run Road Morgantown, WV 26505 Mrs. Algreta Martin (Sister) 20b. Placa of Disposition (Nema of cemetery, cremetory or othar place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maplewood Cemetery November 24, 1997 Kingwood, WV 21. Signature of Funerel Service Licensee 22. Neme end Address of Facility Loring Byers Funeral Directors, Inc. hier the data. Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 8728 Liberty Rd. Randallstown, MD 21133-4784 approximate the mode of dying, such as cardiac or respiratory errest. Approximate intervel Between Onsat and Deeth Myocardial Infarction Immediate Ceuse (Final disease or condition resulting in death) Coronary Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in deeth) Last Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was an eutopsy 1 Yes 2 No 1 Yas 2Pt No 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat:

Physiclan /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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.. Pages 1 and 2 should be fill timent of Health end Mental H tent: If item 27 Is marked out

other traumatic event,

Department of Health er important: If Item 27 Is any injury or other traconce.

deeth with the Maryland

filed within 72 hours after

altimore, Maryland 21215-0020

ed by the ettending physician and detached for use as the buriel-trar The lew requires that the death certificate be signed by t After this certificate or Attending Physician: To the Hospital or Attendir within 24 hours eftar death. To the Funeral Director: A complataly filled in by the fi r death.

Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical þ Completed Be Tol Certification:

Medical

25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Death 1. Netural

3 ☐ Sulcide 4 Homicide

2 Accident

5 Pending Invastigation

6 Could not be determined

28e. Placa of injury - At home, ferm, street, factory, office building, etc. (Specify)

12 inpatiant 2 ER/Outpatient 3 DOA

28c. Injury at Work? 28b. Tima of

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Dascribe how injury occurred

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number AT2438946

29d. Date signed (Month, Day, Year) November 20,1997

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

K-best M'Kinney, DO.

D.O. 201 E. Univ. Pluy, Balt., MD Z1218 Robert McKiNNEY,

State Registrar 31. Dete filed (Month, Dey, Year) NOV 2 5 1997

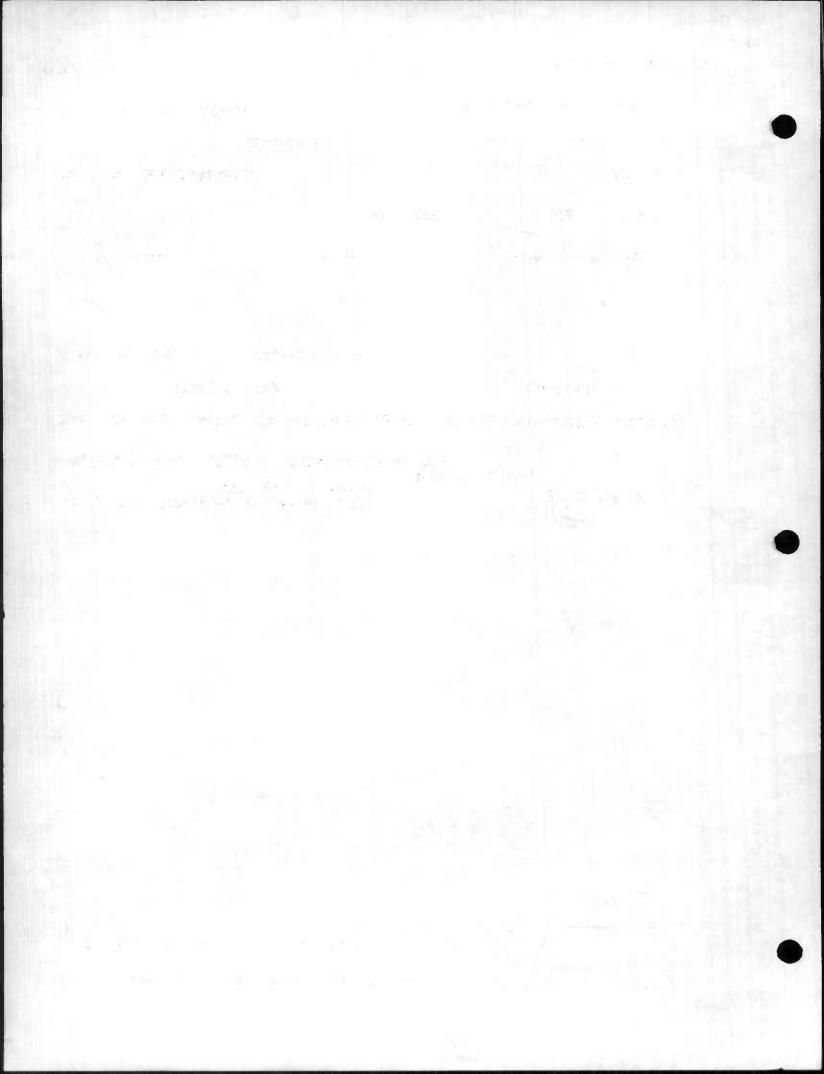
29b. Signature and title of certifier

932 Registrar's Signature Navidson-Randell MARKETT TITLE SCHOOLS

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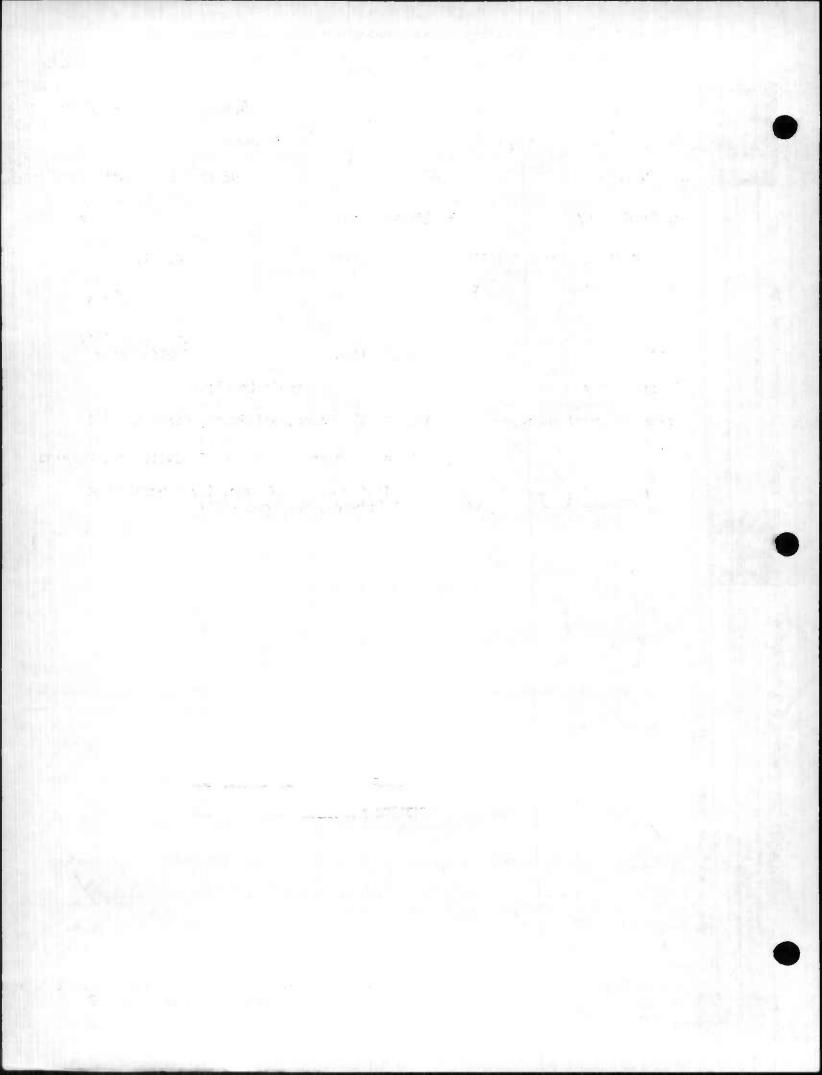
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ч	/Medi		4e. Facility Name (If not institution, give street end number)		4b. City, Town, or L	NOVEMBE ocation of Death	ER 23 1	997 of Death	12:55 A
4	Examir	ner	408 W. FRANKLINTOWN RD,		BALTIMOR		40. County	N/A	
H	Funeral		5. Sociel Security Number 6. Sex 7. Aga (In yrs. lest birthd	ey) if Under 1 Year	If Under 24 Hrs.	8. Dete of Birth (Month, Dey,	Marcal		ece (State or Foreign
Ш	Director		212-90-3947 ^{1⊠ M 2□ F} 35 Yrs	Months Days	Hours Min.	September	26,1962	Mar	yland
	and w		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10	Od. inside City Limits
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	ith the Marylar or 28a-f show	Director	10e. Street and Number	10f. Zip Code		1	Og. Citizen of W	/het Count	iry?
	h with		4204 Seidel Avenue	2120	6		Unit	ed St	tates
	arms arms	Funeral		3. Was Decadent of		pecify Yes or No-	14. Rece	a - America k, White, e	an Indian,
20	72 hours after death with the Manfand naturel, or items 23a or 28a-f show free Example or notified at	by Fu	1 Never Married 2 Married 1 ☐ Yes 2 No	1 ☐ Yes 2 💢 No			Specify		
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Mai	2 9 5			ailing Address (Stree					
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altimore,			21. Signeture of Funeral Service Licensee Mark T. Zavoyna	ervice Corpo 22. Name and Addre		1/28/97	Towson	, Mar	yrand
ñ	permit. Departrimports any inju	7	modet 22	Leonard	J. Ruck,				
	Name of		23a. Part1. Enter the distance of complications that caused the deeth. Do not shock, or heart failure by one cause on each line.	enter the mode of dy	rford Roa Ing, such as cardiec	d Balti or respiratory arre	more, M		21214 Approximate Interval Between
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	0 00	sicla	Part II. Other significent conditions contributing to death but not resulting in the	e underlying cause gi	iven in Part I.	23b. Did to	bacco use con	tribute to	the cause of death?
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tecords,	sw requi	Completed by				24e. Was e		con	re autopsy findings ilebie prior to appletion of cause leeth?
	T ata					1 2 Ye	es 2□No	192	Yes 2□ No
VII		o Be	25. Was case referred to medical examiner? Hospital:	Ot Ot		th (Check only on	-		
INISION	To the Hospital or Attanding Phys within 24 bours afted asth. To the Funeral Director: After his complately filled in by the funeral di	Medical Certification: To	27. Manner of Death 1 Naturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Typ. 326) 1 Inpatient 2 ER/Outpe 28a. Date of Injury. 28b. Time Injury of 11/23/97 found 28e. Placa of Injury. At home, farm, building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, de and manner stated. 29b. Signature and title of certifier	street, fectory, offica eeth occurred at the trinvestigation, In my office. 29c. Licen. O.C.	ine, date and placa, opinion, death occur	Baltimore, end due to the ce red at the time, de	reet end Number, Stete) 408 Maryland	er or Rurel N. Fra nner as sta and due to	Acute Number, Inklintown Rd. ated. the ceuse(s) Dey, Year)
	Sta Registr		David R Fine (er 31. Date filed (Month, Dey, Yeer) NOV 2 5 1997 ▶ June Davidse	111 Pen	n Street,	Baltimo	ore, Mar	ylan	1 21201



State of Maryland / Department of Health and Mental Hygiene Q 7 25621.

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aminer	•	4a. Fecility Name (If not institution, g Johns Hopkins	rive street end number) [+05 p1+a]				11 11	Location of Death	4c. County	y of Death	
eral tor		5. Social Security Number 6. 213-30-7596 Usuel Residence of Decedent	Sex 7. Age	(In yrs. last bir	Yrs. If Ur Mont	nder 1 Year hs Days	If Under 24 Hrs Hours Min		h y, Year) 1933	9. Birthplece (Sta Country) North Ca	
by Funeral Director	-	10a. State 10b. County		10c. City, Tow	n or Location				73 - 74 18	10d, Insid	e City Limits
tor	5 1	Maryland N/A		Balti	more C	ity					Yes 2 No
Director	3	10e. Street and Number			10f.	Zip Code			10g. Citizen of	What Country?	
- E	2	1400 Madison Str	reet Apt 115	5		21217			U.S.A		
by Funeral	2	11. Maritel Stetus 1 □ Never Married 2 ☒ Merried 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces?	ver In U,S.		s 2 XNo	dispenic Origin? (S an, Mexicen, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rad Bia	ce - Americen Indian ick, White, etc. by: Black	n,
ated		15. Decedent's (Specify only highest g	Education	16a.	Decedent's U	Jsual Occup	pation during most of wo d)	urkina	16b. Kind of B	Jusiness/Industry	
Completed		Elementery/Secondary (0-12) 12th	Coilege (1-4or 5+)	Sanita		d) most or we	, King	Baltimo Public	ore City Works	
Be		17. Fether's Neme (First, Middle, Las	st)					me (First, Middle,		me)	
To		Docary Terry						Locklean			
		19a. Informant's Name/Relationship Sharon Edwards/Da						u <i>ral Route Numbe</i> ltimore,			
	-	20a. Method of Disposition	augirter					Date Date		- City or Town, Stet	
		1 Donation 5 Other (Spec			Disposition (by, crematory) Memoria			11/24/97		more, Mar	
		21. Signature of Funeral Service L2 23a. Penti. Enter the disease, or conshock, or heart failure. List only	0//	20	Will	iam C	ss of Fecility Brown Maryla	Community	y Funera	al Home	
		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line	S. 1 's				o or respiratory ar		Approxi Interval Onset a	Between and Death
		rosalting in dodlin			7702007.77					10	hour
edical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cons	ue to (or es a due to (or as a due to (or as a d	Lear consequence	t Fo	ulure			100	lears
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Item: 1 per Physician, items; 24a, 25, 29a G-753 Certificate of Death edent's Namé (First, Middla, Last) 3. Time of Deeth Dete of Deeth 56 Month CATHARINE TRAUB woender 161997 4b. City Town, or Location of Death 4a. Facility Neme (If not institution, give street end number) 4c. County of Death Blemore
If Under 24 Hrs. 8. Dafa of 5. Social Security Numb Baltimore City Birthplace (State or Foreign Country) 8. Data of Birth (Month, Dey, Yeer) 1 M 2 F Months Deys Hours 50 9988 Moust 21,1908 Wisconsin Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Abingdon Maryland 1 Yes 2 No 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 610 West Baker Avenue 21009 U.S.A. 12. Wes Decedanf Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, atc.) Race - American Indien, Bieck, Whita, afc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Giva Yaar or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: White 3 ₩ Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) Ornamental Horticulturist Consultant 12 4 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Warren Bullock Irene Bullock 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Richard Kimberley Traub/son 176 Piney Hill Road, Airville, Pennsylvania 17302 20b. Place of Disposition (Nema of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name end Address of Facility
State Anatomy Board, 655 W. Baltimore Street Director lace Baltimore, Maryland 21201 23a. Purt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of). Due to (or es e consequence of): pulselessness Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 28. Plece of Deeth (Check only ona)

Physician /Medical Examiner

sician end buriel-transit

physician s the buriel

Por

signed by the a

certificate hes

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the Hospital or Attending F hin 24 hours effer death. the Funeral Director: After

within 24 hours eft To the Funeral Di completely filled in

Physician/Medical

Completed

Be

edical Certification:

Box 68760

P.O.

Records.

Division of Vital

Physician

/Medical

Examiner

Director

r than "natural", or items 23s or 28s-f the Medical Examiner must be notifie

Baltimore, Maryland 21215-0020

pormit. Pages 1 and 2 should be filed within Dopartment of Health and Mental Hygiens. Important if item 27 is marked other than any injury or other trainment.

2/3

Director

Funeral

by

Completed

Be

10a Steta

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest

25. Wes case referred to medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes XX No Maymer of Deeth Naturel 5 Pending investigation

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Deta of Injury (Month, Dey Year) 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a, Certifier

∠ Accidant

3 Sulcide

4 Homicide

28e. Pleca of Injury - At home, ferm, straef, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

Miles Certifying Physician: To the best of my knowledge, deeth occurred at fine time, dete end plece, end due to the ceuse(s) end manner es steted.

| Certifying Physician: To the best of my knowledge, deeth occurred at fine time, dete end plece, and due to the ceuse(s) and menner steted.

29b. Signature end title of certifier

29c. Licansa number

29d. Date signed (Month, Dey, Year)

eted cause of deeth (Item 23e) (Type, Print) 505

OI 31. Date filed (Month, Dey, Year)

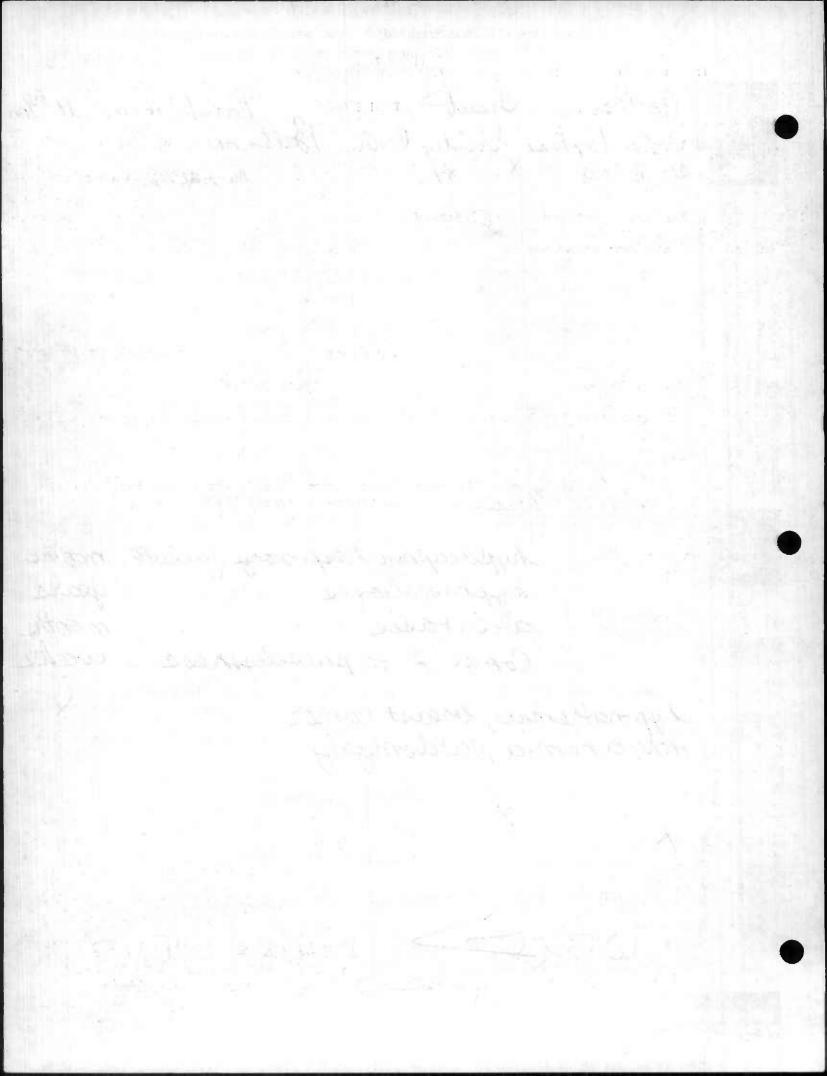
00

6 Could not be

32 Registrar's Signeture

10

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** Liivi Irene Vaigro 23, 1997 2:45 AM November /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 4700 Long Green Road Glen Arm
If Under 24 Hrs. Baltimore If Under 1 Year Months Days Birthpiece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 1 M 2 XF 217-30-5281 Yes Director 69 October 23, 1928 Estonia Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-1 ahow any Injury or other traumatic event, the Modical Educative marker inclined as any Injury or other traumatic event, the Modical Educative marker inclined as 1 ☐ Yes 2 No Director Maryland Baltimore Glen Arm 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 4700 Long Green Road Funeral 21057 United States 12. Was Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Merried 2X Married 1 Yes 2 No if Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elemantery/Secondery (0-12) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Jaan Pihelgas Armanda Luik 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Mr. Aado Vaigro / Husband Same as Item 10e. 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 N Burlel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemeterv 11/26/97 Baltimore, Maryland Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23e. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset end Deeth **Physician** /Medical Immediete Cause (Finel diseese or condition rasulting in deeth) Carcinoma of lungs with metastasis 1 year Examiner Due to (or es e conseguance of): Examiner attanding physician and for use as the bunal-fran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760, Physician/Medical Due to (or es e consequenca of): Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying causa given in Pert I. the detached 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown by 24a. Wes en eutopsy 24b. Were eutopsy findings aveilebla prior to complation of cause of deeth? Completed peed paga 2 has 2 2 No certificata 1 Yes 1 ☐ Yas 2 ☐ No i or Attending Physician: after death. Director: After this certifica 25. Wes casa referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 1 inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Deeth 1 Naturel 28b. Time of 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) Placa of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 3 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data end placa, end due to the cause(s) end menner es steted. 29a. Certifiar Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end menner steted. To the Within 2 29c. License number 29d. Dete signed (Month, Dey, Year) D14959 11/24/97

4000 Erdman Avenue Baltimore, MD 21213

State Registrar

30. Name end eddrass of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

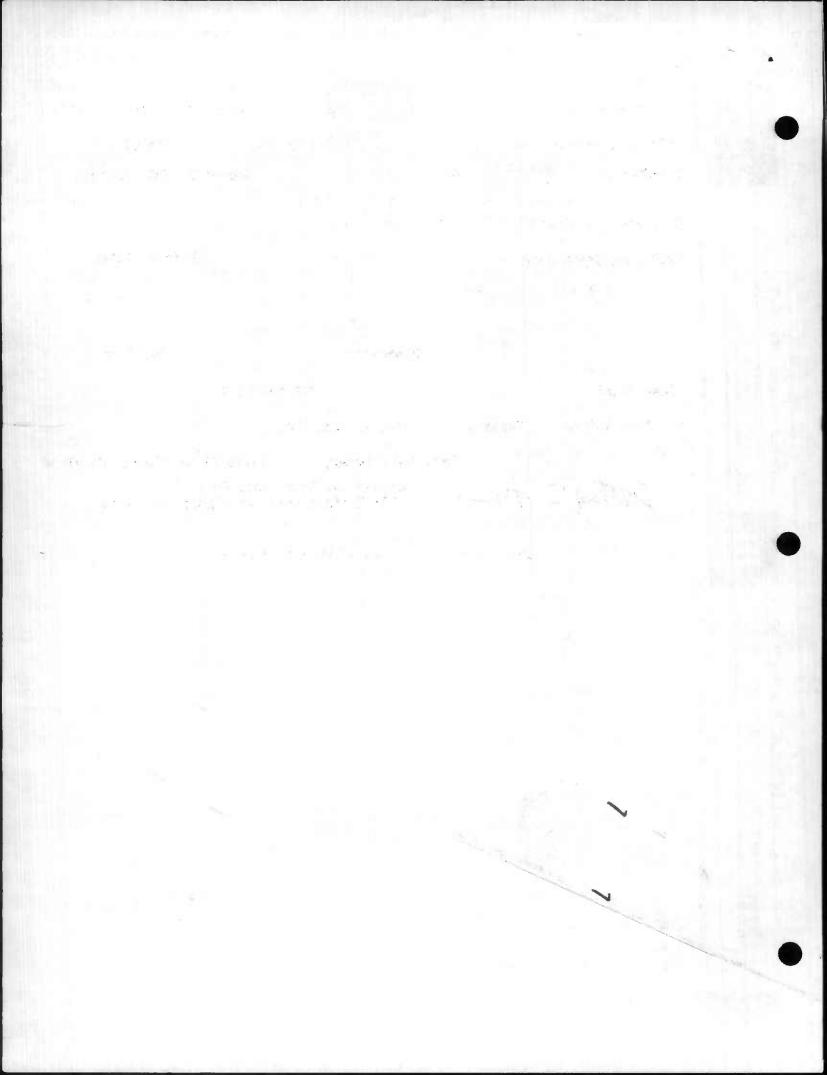
Pulia Davidson

Felix Tan, M.D.
B1. Deta filad (Month, Day, Yaar)
NOV 251997

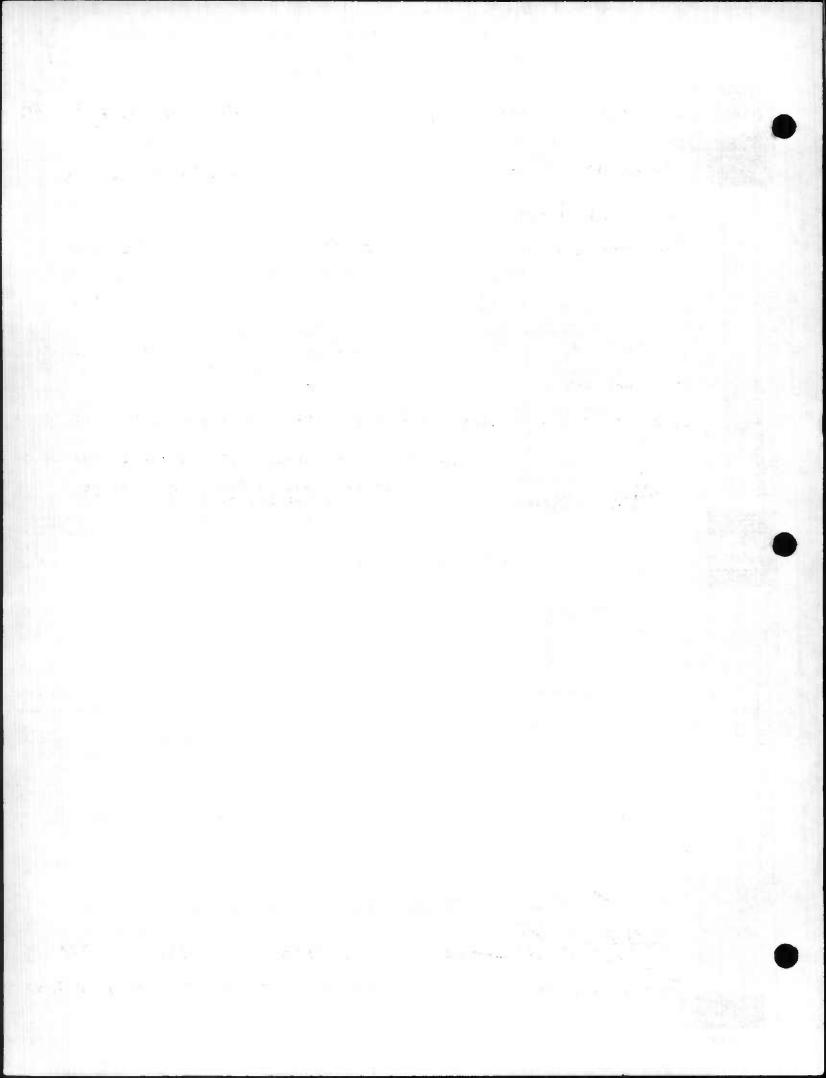
31. Deta filad (Month,

DHMH 16 Rev 6/95

Division of Vital Records. P.O.



					Cei	rtificate	of	Death			Reg. No.				
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Physicia /Medic		EVELYN C	WILL	DULH BU	1					NOV	2/		1997	3:10	AM
Examin		4e. Fecility Neme (If not Institution, g	ive street end nur	mber)						cation of Deat			of Death		
		405 Ridge Roa				Williams				City		owaı			
uneral irector		195-10-0138	Sex 1 □ M 2 ∏ F	7. Age (In yrs. I. 84	est birthdey) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Dete of Bir Feb. 2	Year)	913	Count	ece (Stete or try) 1 and	r Foreign
marked other than "natural", or items 23s or 28s-f show umstic event, the Medical Examiner must be notified at		Usuai Residence of Decedent 10a. Stete 10b. County		10c. City	, Town or Lo	cation							10	d. Inside Cit	v Limits
nctried at	ctor	Maryland Balt	imore		butu	S								1 ☐ Yes	
	Funeral Director	10e. Street end Number 5507 Sycamore	Avenue			10f. Zip C 212	^{ode} 27			1	10g. Citi Unit	zen of V	What Count Stat	ry? ces	
ner must	ner	11. Meritei Stetus	12. Wes Dece Armed Fo	edent Ever in U,	S. 13.	Was Deceder	nt of H	ispanic Orig	in? (Spe	ecify Yes or No	- 1		e - America		
1000	þ	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes If Yes, Giv Yeer or Do	No No		1 □ Yes 2		Specify:		, mount, otal,			whi		
dical	Completed	15. Decedent's (Specify only highest of	Education irede completed)		16e. Deced	dent's Usuei (kind of work DO NOT use	Occup done	ation durina most	of work	ína	16b. Ki	nd of Bu	siness/Ind	ustry	
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inc ev	To Be	Lawrence Gibs	-					Anna					-/		
5		19e. Informant's Neme/Reletionship J. Donald Will		son						el Route Numb					1042
do a		20a. Method of Disposition 1 ☑ Buriei 2 ☐ Cremetion 3	□ Bemovel from 5	CE	metery, crer	sition (Neme netory or oth	er pled	xe)		Dete			City or Tov		
lury		4 □ Donetion 5 □ Other (Spec	cify)	Lot						1/24			ore,	1aryl	and
any injury or other tra		21. Signature of Futiern Service the	tran		Ai 1	mbros 328 S	Addre e l ul	ss of Fecility Funer phur	al Spr	Home,	Ind oad	· .	Arbi 212	utus 227	
Ш		23a. Pert1. Enter the diseese, or co shock, or heert feilure. List on	mplications thet cay	aused the deeth	. Do not ent	er the mode	of dyln	g, such as o	cardlec o	or respiretory e	rrest,			Approximata Interval Betw	veen
cian lical	П	Immediate Ceuse (Finel	0	1./. 4									1	Onset and D	eetn
iner		disease or condition resulting in deeth)	e. <i>PA</i>	NCREA			ER						٥	NE MA	. 14
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e as the burial-transit	Examiner	Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Disease or injury	b	Due to (or	as a conseq	uenca of):							1		
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130 88 1	2	resulting in deeth) Lest	d												
shed for us	cla	Pert II. Other significant conditions	contributing to de	ath but not resu	iting in the u	nderiving cau	se div	en in Pert I		23b. Did	tohacco	UBB COL	atribute to	the cause o	f death?
detached for us	Physician/						00 9				Yss 2		3 □ Prob		Unknown
2	dby									24e. Wes	on outor	2014	24h We	re autoney fi	ndings
should be	ete									perfo	med?	, s y	con	re autopsy fi llable prior to apletion of ca leath?	ause
rector, page 2	Completed									10	Yes 2	9 No		Yes 2 1	No
stor, p	Bec	25. Wes case referred to medical						26. Place	of Deeth	n (Check only o					
dire	2	axaminer? 1 ☐ Yes 2 ☑ No			R/Outpatien	t 3□ DOA	Oth	er: 4 🗆 Nur	sing Ho	me 5 Resi	dance (6 🗆 Oth	ar (Specify)	
e funeral di		27. Menner of Deeth 1 ☑ Netural 5 ☐ Panding 2 ☐ Accident investigeti		h, Dey Year)	28b. Time of Injury	28d	Vori	yet k? Yes 2 □ N		28d. Describe	how injur	y occurr	ed		
d in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not determine	be d 26e. Pieca buildin	of Injury - At horng, etc. (Specify,	me, lerm, str	eet, fectory, o	office			281. Location (. City or Too	Street an wn, Stete	d Numb	er or Rural	Route Numb	ber,
completely filled in by the funeral director, page	edicai C	29e. Certifier (Check only one) 1 ☐ Certifying F	Physician: To the laminer: On the ba	isis of examinet	rledge, daeth on end/or inv	occurred at restigation, in	the tin	ne, deta end pinion, deeti	l place, o	end due to the ed at tha time,	cause(s) data and	and ma	nnar as sta	ated. the cause(s)	
omple		29b. Signeture and title of certilier	and menn	ioi stotou.		29c. l	icens	e nu <i>m</i> ber			29d. Det	a signed	d (Month, E	Dey, Year)	
. 0		11.0	h	- MD		7		-186	0					1997	
	-	30. Neme and address of person who	completed cause	e of deeth (item	23a) (Tvpe.	Print)									
		JONATHAN FISH.	MD 346	O EUIC	OTT CE	NTER	DRI	VE SI	UITE	103 E	uico	H C	119,	MD 2	1043
Stat		31. Dete liled (Month, Day, Year)	32. Re	6 EU/C. egistrar's Signati fund Dav	urg Karon-In	andell									
Registra	r	G Z VUN	וטטו		4-4-00-4										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Day November 21, 1997 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOSPITAL BALTIMORE Under 24 Hrs. 8. Date of MARY land 5. Sociel Security Number GENERAL 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State of Foreign **Funeral** Months Deys Hours 216-54-7159 Usual Residence of Decedent 10 M 20 F Director 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. inside City Limits the Medical Examiner must be notified 12 Yes 2□No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a Funeral 110 death 12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2□No If Yes, Give Year or Dates: Specify: Completed by wed 4 Divorced If Yes, Gi Year or D 15. Decadent's Education (Specify only highest grade completed) 3 Widowed American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) M pino marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother of Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If itam 27 is marked oth Jury or other traumatic even Be eny 0 19e. Informant's Name/Relationship (Type, Print) (DAUG NG, 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of competery, grematery or other place)

ARDIOLOGICAL PROPERTY OF STREET PLACE OF THE PLACE OF T enise 20a. Method of Disposition 1 ₽ Burial 2 □ Cremation 3 □ Removel from State permit. Page Department of Important: If any Injury or 2 4 ☐ Donation 5 ☐ Other (Specify) bulus hem Park
22. Name and Address of Facility
Joseph L. K 21. Signature of Funeral Service Licensee 23a Anti Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest hock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Finel Myocardial disease or condition resulting in death) **Examiner** Due to (or as a consequenca of): Physician/Medical Examiner physician and Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest be axec hronic The law requires that the death certificate Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be detached signed by the 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 □ Probably 4 □ Unknown Division of Vital Records, þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? peen this certificata has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After t 5 Pending Investigation death. 1 Yes 2 No 2 Accident s after death 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner steted. Medical completaly (Check only one) 29b. Signature end title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Fakhar MARYland GENERAL asim1 10

State

Registrar

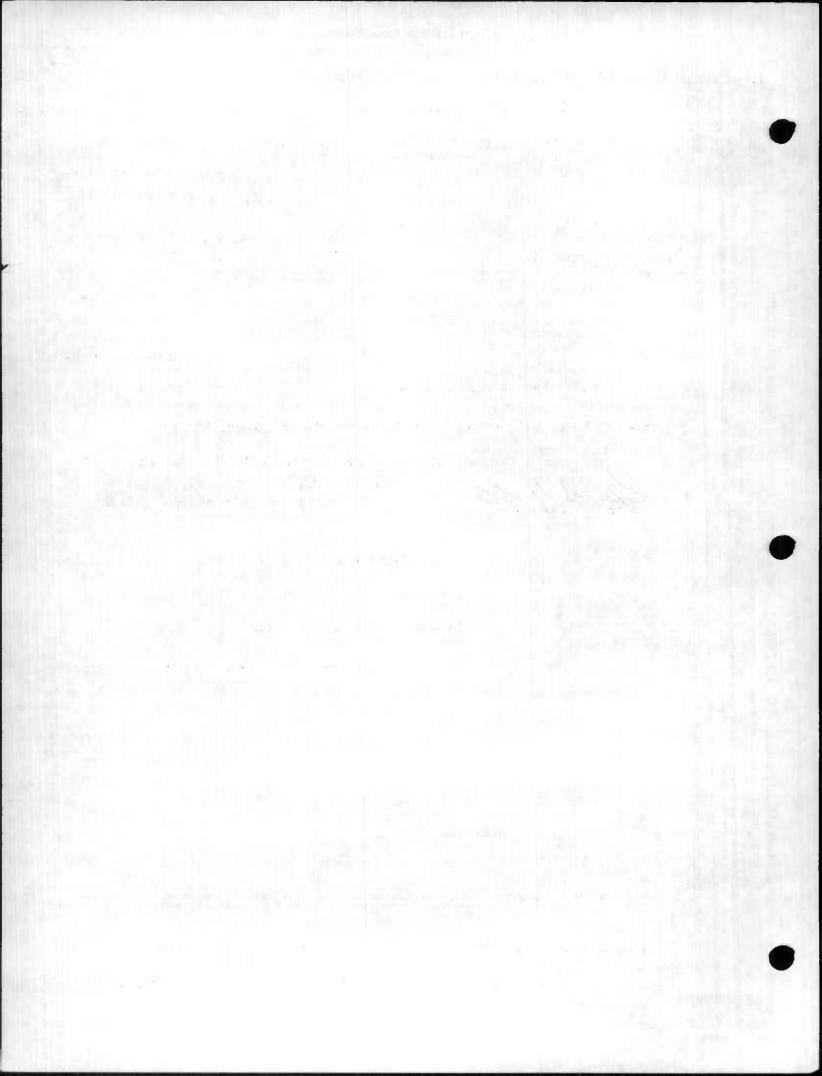
31. Date filed (Month, Day, Year)

32. Registrar's Signature

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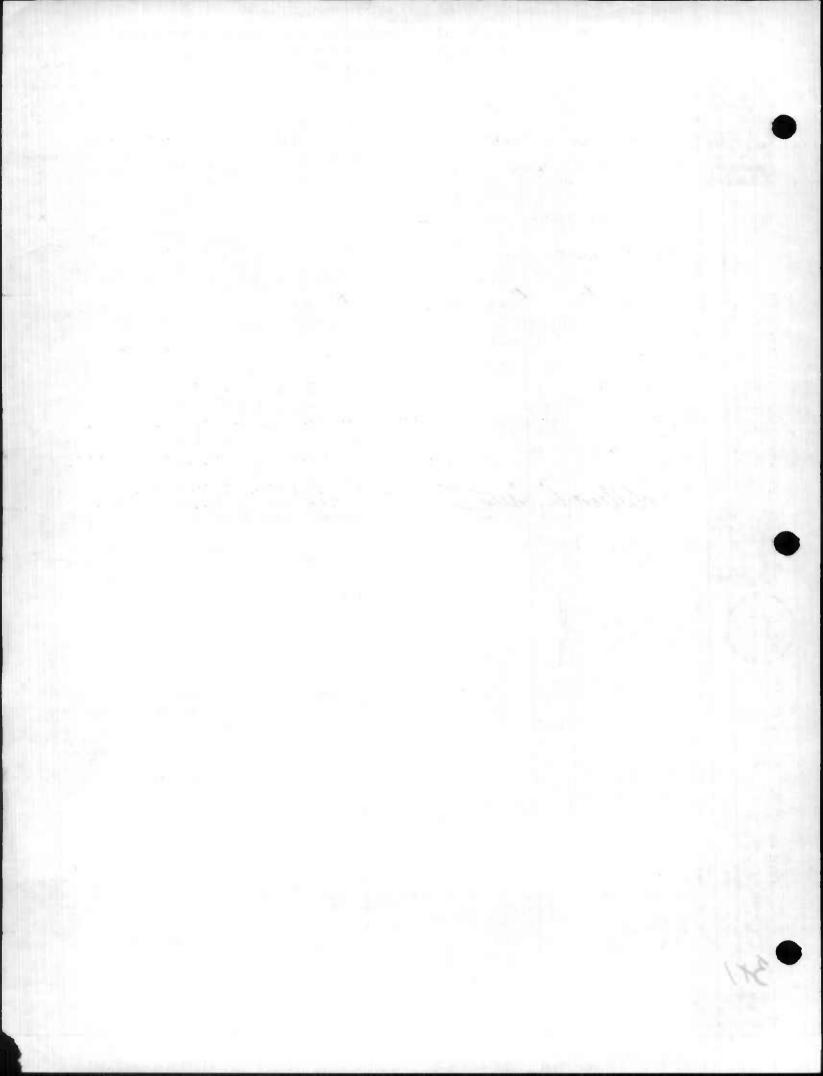
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wo m	Usuei Rasidence of Decedent 10a. Stata 10b. County	10c. City, Tow	n or Location				10d. Inside	City Limits
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vith the Mer t or 284-f si be notified Director	10e. Street end Number		10f. Zip Code		1	0g. Citizen of Wh	at Country?	
23a 23a rai	434 Essexwood	Court	212	21		USA		
permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Merylen Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and Director Dates. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Wes Decedant Ever in U.S. Armed Forces? 1 Days 2 No if Yes, Give 1954-74 Yeer or Detes:	13. Wes Decedant of It Yas, specify Cub		ecify Yas or No- Rican, etc.)	Bleck,	Amarican Indien, White, etc.	
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within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:		stclan: To the best of my knowledge tnar: On the besis of exemination en and manner stated.						e(s)
within To the comp	29b. Signatura and titia of certifier		29c. Licans	se number	2	9d. Data signed	(Month, Day, Year))
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	Bashar Karakas	h. M.D. 3007	E. Northe	rn Parks	Jay Bal	timore	MD 21	2.14
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State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death **Physician** Month CLARK WISE SR. 5:40 PM 1477 Nov 21 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** DULANEY TOWSON HEALTH CARE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthple Country 06-24-1913 OHIO 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min. 1 MM 2□ F 554-12-9989 84 Yrs. Director Usuel Residence of Decedant the Mandand 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner trains be notified at 10d. Inside City Limits Director BALTIMORE 1 ☐ Yes 2 No MD TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 103 OVERCREST RD. 21286 USA daath Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, permit. Pages 1 and 2 should be filed within 72 hours after a Department of Haaith and Mental Hygiena. Important: if Itam 27 is marked other than "natural", or iter eny injury or other traumetin a uncon-Bieck. White, etc. 1 Yes 2 No 1 Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ð Specify: 3 ☐ Widowed 4 ☐ Divorced WWII WHITE Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) 1 2 Coilege (1-4or 5+) SALESMAN SALESMAN 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) ELAM WISE EMMA LEE FOLK 19a. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MR. BUDDY WISE(SON) 775 WHITE OAK DR. BELAIR, MD. 21014. 20b. Piece of Disposition (Neme of cemetary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) GARRISON VETERANS 11/26/97 OWINGS MILLS, MD. 21. Signature of Funerei Service Licensee 22. Name end Address of Fecility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212 23a. Peri1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or haart feliure. List only one cause on each line. Approximata Intervai Batween Onset end Deeth **Physician** /Medical Immediete Ceuse (Finei 6 maths diseese or condition resulting In death) Examiner Dua to (or es e consequance of) Sequentially list conditions, if eny, leading to immediate causa. Enter Undarlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): 68760 Physician/Medical Due to (or es e consequance of): Box Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. P.O. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were autopsy findings aveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? cartificata has 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No of Vital the Hospital or Attanding Physician: nin 24 hours after death. Be 25. Wes case rafarrad to medical 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 10 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) 27. Mannar of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Division Aftar 1 Natural 5 Pending s after death. 1 Yes 2 No Invastigetion 2 Accidant 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) in by 4 Homicida To the Hospital of within 24 hours at To the Funeral Discomplataly filled it 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) end mannar as stated.

| Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, data and piece, and due to the cause(s) end menner stated. 29e. Cartifian 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) lan levill, M.D. 047813 Nov 24 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) KARAKASH 3007 E. NOrthern Porking Boltimore MD 21214 32. Registra = Signature 31. Dete filed (Month, Day, Year) State NOV 2 5 199 Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year ALMA 20LLO 11:15 AM 11 4a. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Laurel Regional Hospital Laurel Prince George's If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 1 ☐ M 2 🛛 F 473-18-5127 87 Yrs MN June 12, 1910 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits Columbia Howard 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5400 Vantage Point Road 21044 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black White etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementery/Secondery (0-12) College (1-4or 5+) Government Administrative Assistant 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Ole S. Anderson Carrie T. Olson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Carol Fawley (Niece) 7825 Hemingway Ave. San Diego, CA 92120 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete Nov. 1 ☐ Buriel 2 【Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation Service 18, 1997 Hampstead, MD 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Witzke Funeral Homes, Inc. Robert 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 5555 Twin Knolls Rd. Columbia, MD Approximate tritervel Between Onset and Deeth Sepsis Immediate Cause (Final disease or condition resulting in death) 15-20 Days Due to (or es e consequence of): Failure Resinizatory +3 WK Due to (or es e consequença of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Renal Pailuro 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Tes 200 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

permit. Pages Department of Important: If it any injury or o

Physician

/Medical

Examiner

MD

Directo

Funeral

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2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

nt: If tem 27 is marked other than "natural", or items 23s or 28s-4 show

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

Division of Vital

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7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Madical Examiner must be notified at

other t

Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest physician Physician/Medical 94 88 980 signed by the a d be detached t à

27. Manner of Deeth

Completed Be 2 Certification:

certificate D880 異 page 2 certificate 100 funeral or Attending P after death. Director: After t

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Registrar

To the Hospital of within 24 hours at To the Funeral D completely filled it 29e. Certifier (Check only one) Medical

1 ☐ Yes 2 No

2 Accident

3 Suicide

4 Homicide

29b. Signeture and title of cartifier Mulo

5 Pending

6 Could not be determined

investigetion

MD

28e. Dele of Injury (Month, Dey Year)

10 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

29c. License number

28c. Injury et Work?

🗖 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner as steled.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examinelion end/or Investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year) 11-16-97

28f. Location (Streef and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

TARMIT S AUTLA 5638 ANNA! 5638 Annapolis

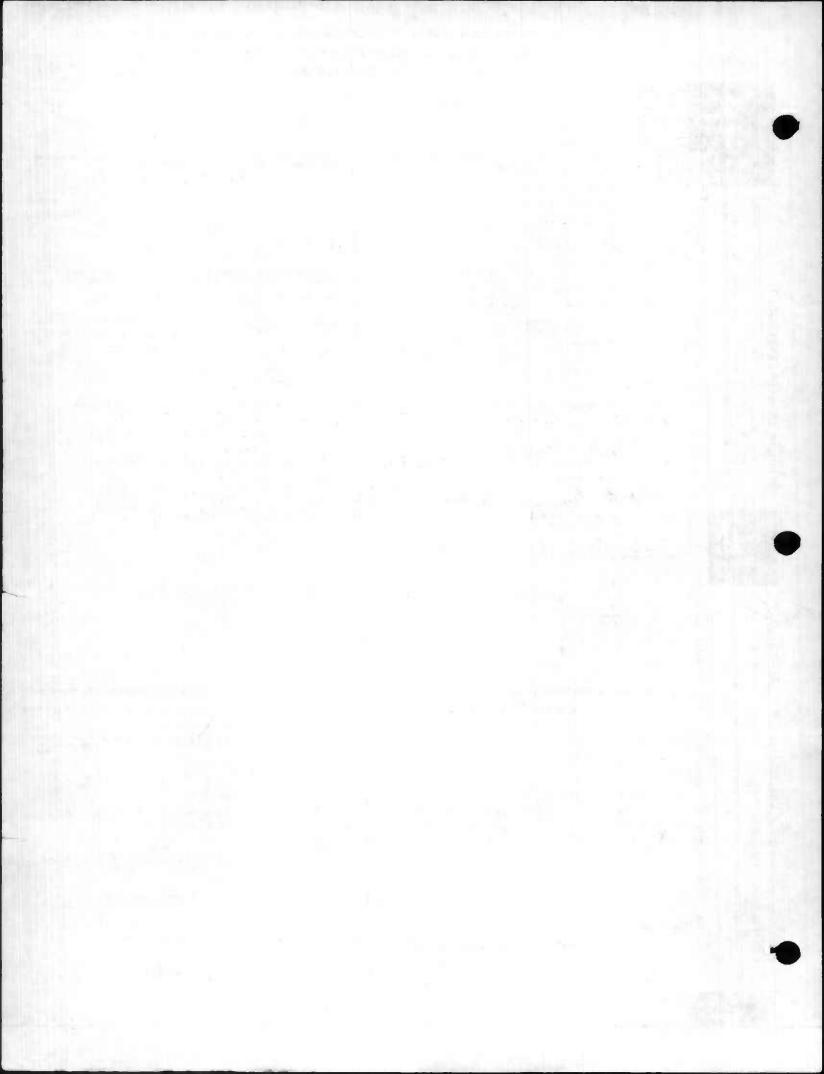
RD #13 BLADENS BUR MD 20710.

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

32. Registrar's Signeture

Suna Way Son - Rende St. 31. Dete filed (Month, Dey, Yeer) NOV 2 5 1997

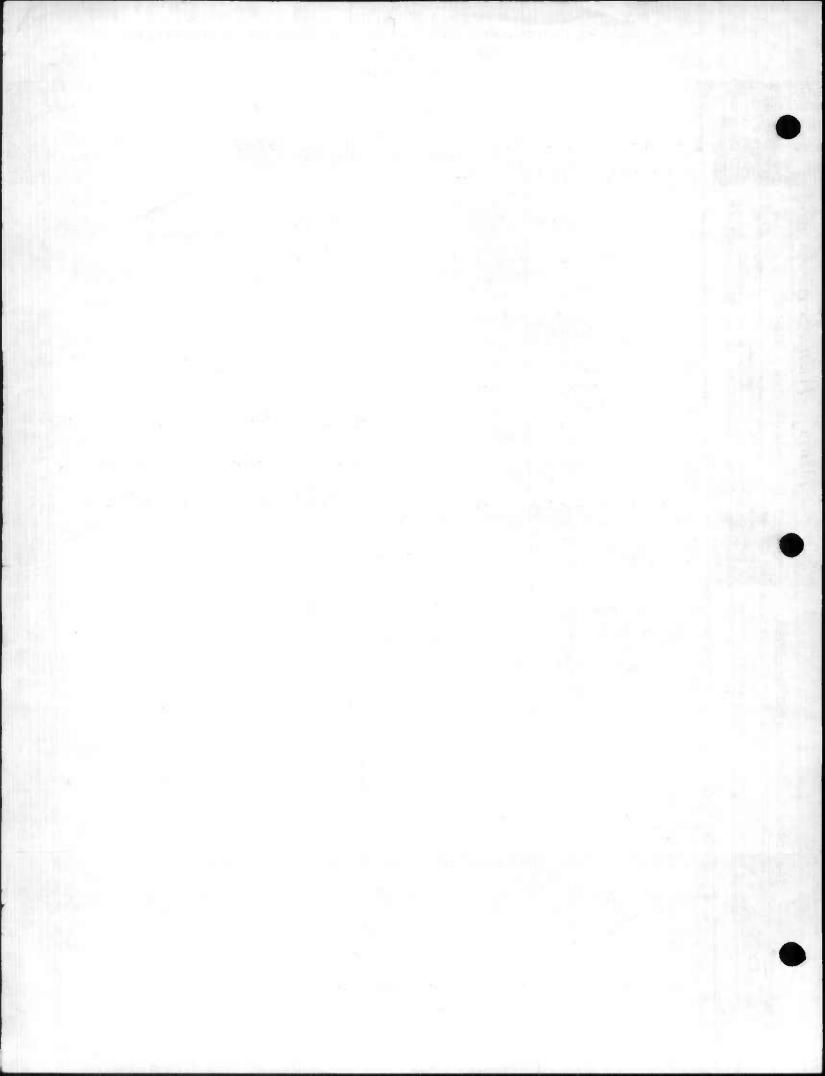


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent'a Nama (First, Middle, Lest) 2. Date of Death **Physician** Month Mary Jane Anderson NOVEMBER 2,1997 0420 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SALISBURY
If Under 24 Hrs. 8. D
Hours Min. (A PENINSULA REGIONAL MEDICAL CENTER WICOMICO If Under 1 Year 8. Date of Birth (Month, Dey, 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2√F Days 171-26-4201 64 Yrs. Director 09-19-1933 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Ocean City Worchester 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 245 South Ocean Drive or Items 23a 21842 USA Funeral 12. Was Decedant Evar in U,S Armed Forces? 14. Race - American Indian, Bieck, Whita, atc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1 ☐ Yas 2 🛣 No If Yes, Giva Year or Detes: 1 Navar Married 250 Married Maryland 21215-0020 1 Yes 2 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary DuPont Chemical Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be named of Health and Mental 1 Barbara Esbenshade is marked Harry Galbraith OL 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other James C. Anderson, Husband 245 South Ocean Drive, Ocean City, MD 20b. Piaca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/06/97 Kennett Square, PA Union Hill Cemetery 21. Signature of Funaral Servica Linguis 22. Nama and Address of Facility MITCHELL-SMITH FUNERAL HOME, Havre de Grace, M DellaVecchia, Reilly & Smith, West Chester, PA 23a. Part1. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ASCVD Examiner Due to (or as e consequença of) or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as e consequence of) Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medicai Due to (or as a consequenca of). P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed has this certificata 1 Yas 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 11 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Dey Year) Certification: 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending ours after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homleide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner as stated. Medical Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signature and tillig of certifier 29c. Licanse number 29d. Date signed (Month, Dey, Yeer) 11/2/47 HSOUS) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 108 PINEBLUFF ROAD, SALSBURY, ND. 21801 SNYDER, D.O. CHRISTOPHER 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Makin Structur Rardall NOV 7 Registrar

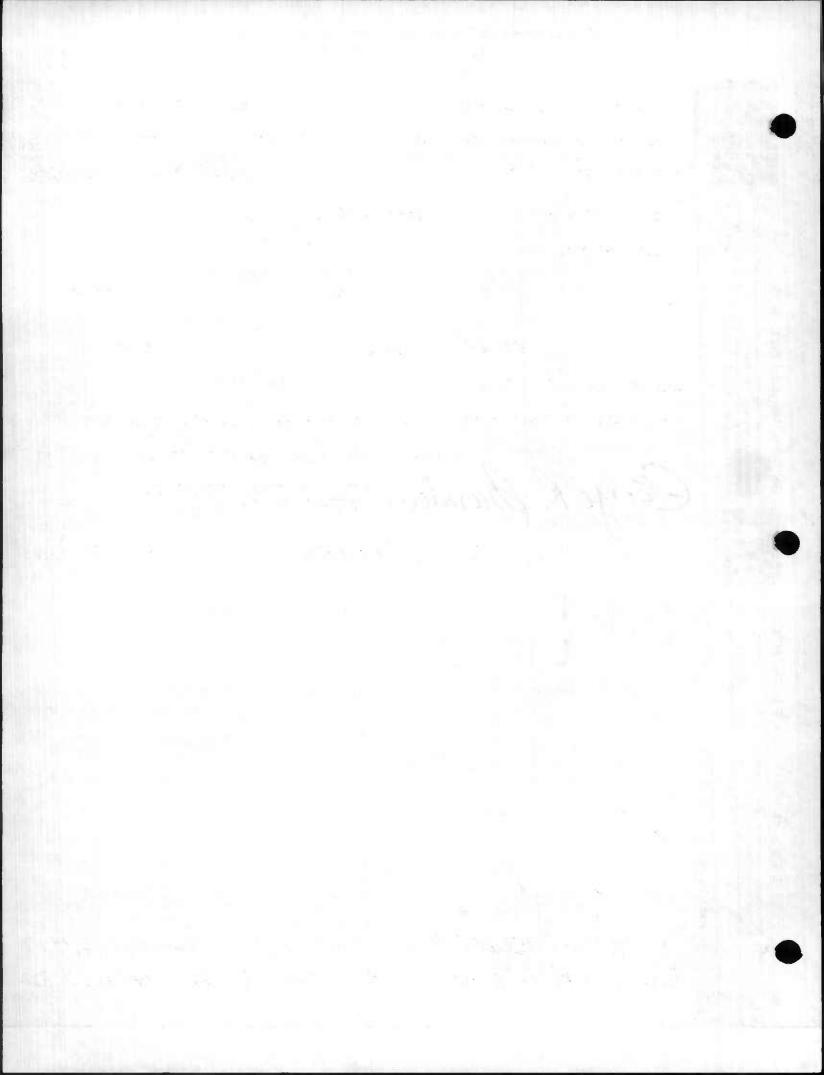
DHMH 16 Rev 6/95

ANDERSON



State of Maryland / Department of Health and Mental Hygiene 9 7 3 5 6 3 3

					Cer	tificate of	Death		Reg. No.	0 (
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Physiciar /Medica		PRENELLA	M. AB	BOTT				NOV.	11, 19	9°7	8:30 P			
Examine		4e. Facility Name (If not institution Montgomery			al		4b. City, Town, or Olney			of Death	RY			
Funeral Director		5. Social Security Number 577-40-0859	6. Sex 1 ☐ M 2茲 F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Yeer Months Days	If Under 24 Hr Hours Mir	. (Month, D	orth Yeer) 0,1908	9. Birthple Countr N . C	ace (Stete or Fore			
Maryland -I show	Jol	Usuel Residence of Decedent 10e. State 10b. County MD Mon	tgomery		Town or Lo	cation C Sprin	g			10	d. Inside City Lim			
sth with the Marylan 23s or 28s-f show and be notified at	Direc	10e. Street and Number 3227 Bel Pr	e Road			10f. Zip Code 209	06		10g. Citizen of V	What Countries . A .	y?			
urs efter des al', or items Experiments	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 Yes	2€ No Give	ē1	Vas Decedent of I f Yes, specify Cub	en, Mexican, Pue	Specify Yes or N no Rican, etc.)		e - America k, White, et				
natur olcal	pateiduo	15. Deceder (Specify only highe Elementery/Secondary (0-12)		(1-4or 5+)	(Give	lenf's Usuel Occup kind of work done DO NOT use retire	pation during most of wi d)	orking	16b. Kind of Bu		istry			
s 1 end 2 should be filed within Health end Mental Hygiene. Item 27 is marked other than other traumatic event, trailing To Be Commit	9	17. Fether's Neme (First, Middle, Stephen Moor					1	ame (First, Middle Hill	e, Meiden Sumem	Θ)				
s 1 end 2 sho of Health end I ftern 27 is me other traums		19e. Informant's Name/Relations Penny Miller							ber, City or Town,					
permit. Pages 1 Department of He Important: If item any Injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (5		Cert	netery, crem	sition (Name of netory or other pla E Best		Date y 11/1	20c. Location - 3/97 F		on, State			
permit. Departr Importa any Inja		21 Signature of Funeral Servica	Liberary /	hund	12 3	Name and Addre	FUNERA		•					
Physician		23a. Pert1. Enter the disease, or shock, or heart failure. List	complications that only one clause on		Do not ente		ng, such es cardie	20850 ec or respiretory	errest,		Approximate Interval Between Onset and Deeth			
/Medical		Immediate Ceuse (Finel disease or condition resulting in death)	a	Lun	g C	HNCt	R				2 year			
axecuted in end in-transit		Page and the time and the	b	Due to (or a		,				1				
eath certificate be axecuted attending physician end for use es the bunal-transit Clan/Medical Examir		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lsst	c	Due to (or as						1				
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by the ached		Lux	r liyardan		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobecco use contribute to the			the cause of dea
S S S								24a. We	s en sutopsy ormed?	avai	re autopsy finding lable prior to upletion of cause			
certificate hes been s rector, page 2 should								10	Yes 2 No		eath? Yes 2□ No			
Physician: this certific ral director,	ם	25. Wes case referred to medica examiner? 1 ☐ Yes 2 PNo	Hospital:	/		Oti	200	eth (Check only						
After thi funeral	- -	27. Manner of Death 1 Naturel 5 Pendir 2 Accident Investi	28a. Date (Mo		NOutpatiens Bb. Time of Injury	28c. Inju	4 LI Nursing	1	idenca 6 Other					
be or Attending P ss after death. al Director: After t ed in by the funera		3 Suicide 6 Could determ	28f. Location City or To	(Street and Number own, Stete)	er or Rural	Route Number,								
n 24 hours n 24 hours he Funer pletaly fill	calical	29a. Certifier (Check only one) 1 Certifyir 2 Medical	Examiner: On the	e best of my knowle basis of examination nner stated.	edge, deeth n end/or inv	occurred at the tilestigetion, in my o	me, dete and plea opinion, death occ	e, end due to the urred at the time	cause(s) and ms , dete end plece, a	nner ss sta and due to t	ted. the cause(s)			
Within To the Company	-	29b. Signature end title of certifie	cottoe	ut 5 11	es	29c. Licens			29d. Date signed					
\		30. Name and address of person KORERT H. 1	who completed cau	use of death (Item 2:	3a) (Type, 1 8/11	Prince	Puilip	Dr #3	Rovem	-y,un	D 208			
State Registrar		31. Date filed (Month, Dey, Yeer)	13 1997 32.	Register's Signatur	dson-A									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** HERMAN ARROMOWITZ NOVEMBER 6 6.00AM 1997 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Rockville t Under 24 Hrs. 8. Hours Min. Hebrew Home of Greater washington Montgomery If Under 1 Year Months | Days 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Sex 1 M 2 □ F 8. Date of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** Days Hours Yrs. Director 098-30-0345 84 May 21, 1913 Canada Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MD Director Montgomery Rockville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23a or 6121 Montrose Road 20852 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Race - American Indian Bleck, White, etc. hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: if item 27 is marked other than any injury or other traumairs avant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Harry Abromowitz Minnie Muntner 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ellen Joy Bezner-Daughter 14601 Country Creek Ln N. Potomac MD 20878 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) Date 20c. Location - City or Town, State Weurial 2 Cremation 3 Removal from Stete Judean Memorial Gardens 11/7/97 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Striving Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction -Daniel Simons 23a. Part Enter the assess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate triterval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA ASPIRATION 4 DAYS Examiner Due to (or as a consequence of): Examiner YGARS DEMENTIA The law requires that the death certificate be axecuted bunal-trans Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as e consequence of): Box 68760, physician Physician/Medical the Due to (or as a consequence of) for use as P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? has page 2 1 Yes 2 No 1 Tyes 2 No certificata of Vital director, 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Division 1 Naturai or Attending s after dea. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours of To the Funeral I completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier Medical (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) Return M.D. 6 1997 36552 NOVEMBER

State Registrar (ALWAR

31. Date filed (Month, Day, Year) NOV1 0 1997 32. Registrar's Signature Julia Savidson Randose mp 20852

POCKVILLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121 MONTROSE

Tell a IVA

State of Maryland / Department of Health and Mental Hygiene

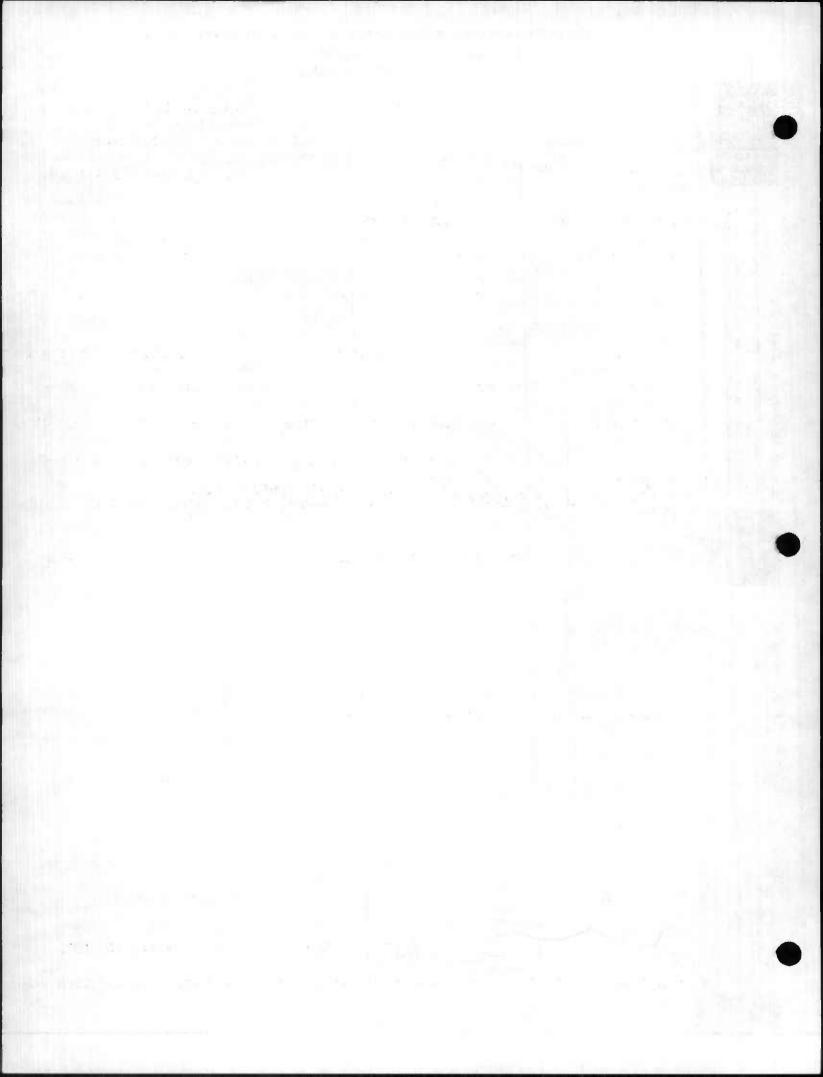
35635 Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Adams Barbara Winn November 10, 1997 8:30 PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6009 Selvyn Road Bethesda Montgomery If Under 24 Hrs. 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (Stete or Foreig Country)

July 18, 1911 Massachusetts Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1□M 2X F 219-68-2923 86 Yrs Director Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 238 6009 Selvyn Road 20817 United States Funeral Hems 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Raca - American Indien, permit. Peges 1 and 2 should be lifed within 72 hours after of Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural" or iten any Injury or other traumatic event, the Medical Evan early and place. Bleck. White, etc. 1 Yes 2XXNo If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ₺ Divorced White Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Children's Book Specialist Self-Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be George Albert Winn Mabel Hartley 10 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) (daughter) Susanna Adams 30 Winding Way, Peaks Island, Maine 04108 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Burlel 2 Incremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 11-14-97 Beltsville, Maryland 22. Neme and Address of Fecility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiratory en shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finet disease or condition resulting in deeth) Metastatic Breast Cancer Examiner Due to (or es e consequence of) Examiner that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest pue Due to (or es e consequence of) Box 68760 physiclan Physician/Medical the Due to (or es e consequence of): attending plant for use as signed by the at d be detached for P.O. Pert il. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Tyes 2 No 3 Probably 4 Unknown Congestive Heart Failure þ Division of Vital Records. The law requires should 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy page 2 hes 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director. 25. Wes case referred to medical axeminer? Be 26. Plece of Deeth (Check only one) Hospital: Certification: To Other: 4 ☐ Nursing Home 5 ☒ Residenca 8 ☐ Other (Specify) 1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Day Year) Menner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred After 1 X Neturet 5 Pending death. investigetion 1 ☐ Yes 2 ☐ No ours after death. eral Director: A filled in by the fo 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 I Homicide To the Hospital or within 24 hours at To the Funeral D edica 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 20 D20367 November 11, 1997 30 Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Joe's P. Kalman, M.D., 6111 Executive Boulevard, Rockville, Maryland 20852-3976 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State who Davidson NOV12 1997 Registrar

State of Maryland / Department of Health and Mental Hygiene 0.7

Physician /Medical Examiner					Certificate of	Death		Reg. No.		0000
/Medical Examiner		1. Decedent's Name (First, Middle, Li	ast)		15		2. Date of De		Year 3.	Time of Death
Examiner		La Rue	М.		Anderson		Novemb			2:30 AM
	_	4e. Facility Name (If not institution, gir	ve street and number)			4b. City, Town, or L	-			
un augl		503 Dennis Avenu	ae			Silver S			ntgomer	y
uneral rector	_		Sex 7. Age 1 ☑ M 2 ☐ F	o (In yrs. last bi	Yrs. If Under 1 Year Months Days		8. Date of Bir (Month, Di	rth ay, Year) 14, 1910	9. Birthplace Country) Pennsy	(Stete or Foreig
	-	Usual Residence of Decedent					-			
뉔	_	10a. State 10b. County			n or Location					nside City Limit
9 0	3 1	ennsylvania Sulliv	ran	Muncy	Valley					I□Yes 2⊠N
ole el		10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
1 6	Ö	RR1 Box 474			177	58		United	States	
or other traumatic event, the Medical Examiner must be notified at	Lalie	11. Marital Status 1 ☐ Never Married 2 ☐ Merried	12. Was Decedent 8 Armed Forces? 1 Yes 2 N If Yes, Give		13. Was Decedent of if Yes, specify Cu		ecify Yes or No Ricen, etc.)		ce - American li ck, White, etc.	
d by	5	3 X Widowed 4 □ Divorced	Year or Dates:			ороску.		Specii	Whit	e
Completed		15. Decedent's E (Specify only highest gr	ducetion ade completed)	168	Decedent's Usual Occu	upation a during most of work	cina	16b. Kind of B	usiness/Industr	у
l g		Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give kind of work done life. DO NOT use retir	red)	9			
្ង	3	8			Laborer			Airplan	ne Engi	ne Plan
B		17. Fether's Name (First, Middle, Last				18. Mother'a Nam				
2	2	Bernley	Anderson			Bert	ha	Glidewe!	11	Durkee
		19a. Informant's Name/Relationship	(Type, Print)	191	o. Mailing Address (Street	et and Number or Ru	ral Route Numb	er, City or Town,	, State, Zip Cod	(e)
once.]	Darla M. Bortz	(daug	hter) !	503 Dennis A	Avenue, Si	lver Sp	oring, M	aryland	20901
		20a. Method of Disposition		20b. Place o	of Disposition (Name of	ace)	Date	20c. Location	- City or Town,	State
		1 ☐ Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont			apeake Crema		1-10-97	Beltsvi	lle. Ma	ryland
	3	21. Signatura of Funeral Source Liga		1 .11	22. Name and Addi	4		DOLOGVI	110, 12	Lylana
Suce		11/201	11.000	04.	Rapp Funer	ral Servic	es, P.A	A.		
	+	23a. Part1 Enler the disease, or conshook, or heart failure. List only	/www	n the death De	933 Gist A	Avenue, Si	lver Sp	oring, M		20910
ta la		Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions,	b	Due to (or as a	consequence of):	n				Years
		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	6						1	
Medical		that initiated events resulting in death) Lest	C.	Due to (or as e	consequence of):					
Medical Examir			d							
cian/M			0.							
y Physician/		Part II. Other significant conditions of	contributing to death bu	t not rasulting i	n the underlying cause g	iven in Part i.	23b. Did	tobacco use co	ntributa to the	cause of death
d by Ph		Intracerebral Tu	mor (Prima	rv Unde	termined)		1 🗆	Yes 2□No	3 Probably	4 XUnkno
by				4					Т	
eted							24a. Was	an autopsy ormed?	avallab	utopsy findings le prior to tion of cause
									of deat	h?
9							10	Yes 2⊠No	1 □ Ye	s 2 No
Comp		25. Was case referred to medical examiner?				26. Place of Dear	h (Check only	one)		
Be Completed			Hospital: 1 Inpatier	nt 2 ER/O	utpatient 3 DOA	ther: 4 In Nursing Ho	me 5 🗓 Resi	idence 6 Oth	ner (Specify)	
Be		1 ☐ Yes 2 ☒ No	28a. Date of Injury (Month, Day)	y 28b.	Time of 28c. Injury We	ury at	28d. Describe	how injury occur	red	
To Be		27. Manner of Death		, our,		Yes 2 No				
To Be									ner or Burel Bo	
To Be		27. Manner of Death 1 🖾 Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of inju	ry - At home, fa	arm, street, factory, office	•	28f. Location (Street and Numb	or or rigital rio	ute Number,
iffication: To Be Comp		27. Manner of Death 1 Naturel 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n Diago of Jaju	ry - At home, fa (Specify)	arm, street, factory, office	•	28f. Location (City or To	Street and Numb wn, State)	or or mararrio	ute Number,
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DHMH 16 Rav 6/95



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5637 Item: 1 Per Phy Film G-754 12-22-97RC Certificate of Death Reg. No 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Nov 9,1997 THORNTON HOGAN ANDERSON **Physician** 09:31am Thorton Hogan Anderson /Medical 4b. Cify, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Silver Spring
If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) Holy Cross Hospital Montgomery Birthplaca (Stata or Foreign Country) Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Months 10XM 2□ F Yrs. 82 Director 403-24-3408 March 31, 1915 Kentucky Usual Rasidance of Dacedant with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show 1 ☐ Yas 2 No Directo Maryland Montgomery Silver Spring 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda United States 1222 Brantford Avenue 20904 Funeral death 14. Race - Americen Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or ite 1 X Yas 2 No If Yas, Give World Yaar or Datas: War 1 Nevar Married 2 Namied Baltimore. Maryland 21215-0020 1 ☐ Yas 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White War Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Collega (1-4or 5+) Elementery/Secondary (0-12) 5± Professor University other traumatic event, 18. Mothar's Nama (First, Middia, Maidan Surnama) 17. Fathar's Nama (First, Middia, Last) Be To Thornton H. Anderson Keturah Hogan

M00831

23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such es cardiac or respiratory errest, shock, or heart feature. List only one cause on each line.

pullendurence

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is in any Injury or other traun pnce.

Physician /Medical Examiner

Box 68760 certificate be

P.0.

Division of Vital Records.

Examiner the attending physician and hed for use as the burial-transit Physician/Medical p Completed page 2 director, Be To funeral Certification: the 3

signed by

certificate has

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After

completely

(Check only one)

29b. Signatura and title of certifie

31. Data filed (Month, Day, Year)

at or Attending F s after death. I Director: After

Approximate Interval Between Onsat and Death Immediata Causa (Final diseasa or condition rasulting in daath) MRREST CARDIO DULMONARY Dua to (or as a consequance of): COROWARY ARTERY DISEASE Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) that initiated avants rasulting in death) Last Dua to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 € Unknown 1 Yss 2 No PERTENSION 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was cesa referred to medical axaminar? 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Yaar) 28d. Dascribe how injury occurred 27. Mannar of Daath 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No invastigetion NA 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian Medical

29c. Licansa number

D18137

20b. Place of Disposition (Nama of comatary, cramatory or other place) November 12, 1997

Montgomery Crematorium, Inc.

22. Nama and Addrass of Facility

19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)

1222 Brantford Avenue, Silver Spring, MD 20904

7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.

20c. Location - City or Town, Stata

29d. Data signed (Month, Day, Year)

Nov 11,1997

Ma

Bethesda, Maryland

To the Hospital within 24 hours a To the Funeral I

Hospital c

State Registrar

NOV 13 1997

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

19a. Informant's Neme/Ralationship (Type, Print)

4 ☐ Donation 5 ☐ Othar (Specify)

20a. Mathod of Disposition

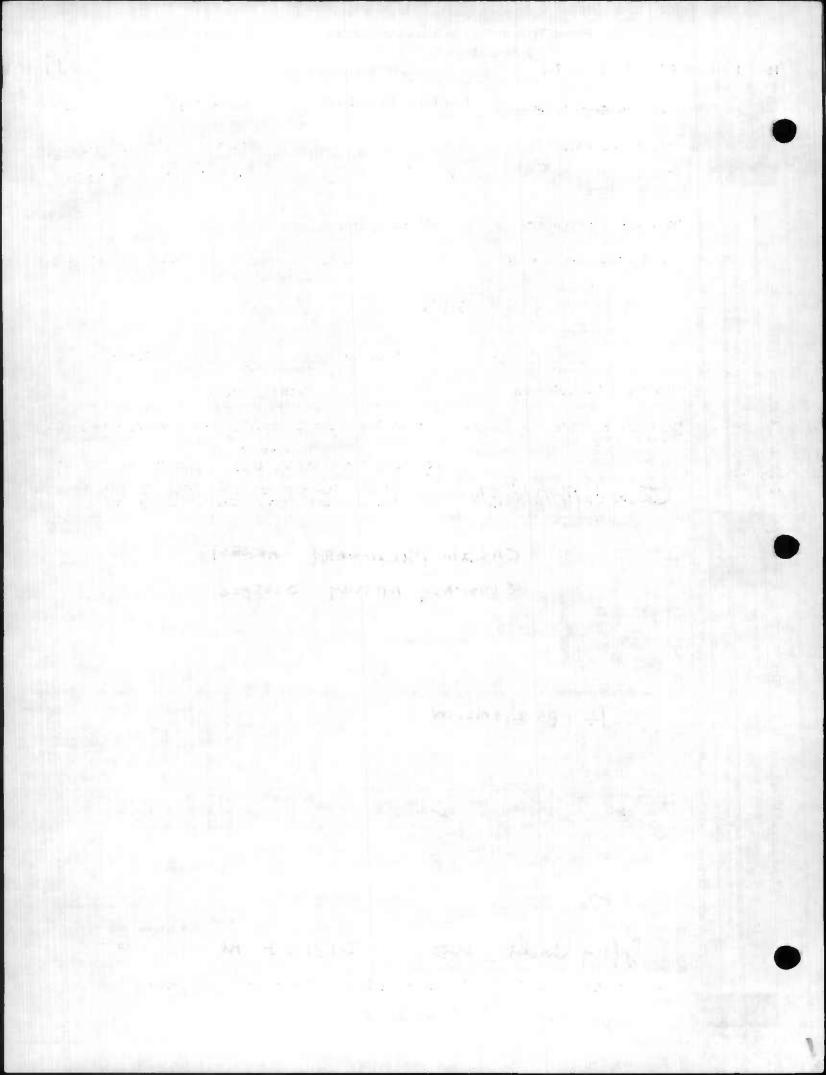
Mary Lou S. Anderson / wife

1 ☐ Burial 2 X Cramation 3 ☐ Ramovai from Stata

32. Registrar's Signature whia Davidson-Mandall

Jeffrey Drobis Md 12201 plum Orchard Drive, Silver Spring Md 20904

UC)



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Nov. 9, Philip Angel
4e. Fecility Neme (If not institution, give street end number) 1997 1400 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery If Under 24 Hrs. Hours Min. May 30, 1915 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign Country)
RUSS1a **Funeral** Deys 11X M 2□ F 214-30-1383 82 Yrs. Director Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location show 10d. Inside City Limits "naturel", or items 23s or 28s-f shouldest Examiner must be notified at Director MD Montgomery Silver Spring 1 ☐ Yes 2 No 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 1401 Blair Mill Road 20910 US death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgln? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed The Medical 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Government traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) . Pages 1 end 2 should be filt ment of Heelth and Mentel H-lant: If itam 27 is marked oth fury or other traumatic evan 18. Mother's Name (First, Middle, Maiden Sumame) Be Moshe Angelevitch Zena Pocrebinsky 19e. Informent's Neme/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) K. Neil Ross-Son-in-law 2203 Aventurine Way Silver Spring, MD 20904 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 ☐Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any injury or King David Mem. Gardens 11/11/97 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Rensee 22. Name end Address of Fecility
Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 20852 Part. Enter the double or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart feilum. List only one cause on each line. Approximate Intervat Between Onset end Death **Physiclan** /Medical Immediate Ceuse (Finel Acute Myocardial Infarction diseese or condition resulting in death) Examiner Due to (or es e consequence of): Respiatory Failure The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest pue Due to (or es e consequence of): Box 68760. physician Physician/Medical the Due to (or es e consequenca of): USB 85 Pop P.O. 1 Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed i Records, by Completed 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveilebte prior to completion of cause of deeth? peeu page 2 certificate 280 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director. 25. Wes case referred to medical Be 28. Plece of Deeth (Check only one) Hospital: 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 No this funeral Certification: 27. Menner of Deeth 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending Investigation 1 Neturel death 1 ☐ Yes 2 ☐ No Director: A in by the f 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 6 To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) Nov 10, 1997 30. Neme and eddress of person who completed cause of deeth (ttem 23e) (Type, Print) Gita Bakshi 9406 Old Georgetown Road Bethesda, MD 20814 32. Registrar's Signeture State Registrar

A ROLL OF THE REAL PROPERTY OF marks will a server miles.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day 31 : 15 Pm THOMAS ROY BROOKES, DCTOBER 199 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fallston General Hospital Fallston Harford If Under 1 Yaer | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Aug. 3, 1916 9. Birthplaca (State or Foreign Country) Maryland Months Days Min. HXM 2□ F Hours Yrs. 206-05-2218 81 Usual Residence of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1901 Emmorton Road 21015 USA 12. Was Decedant Ever In U,S. Armed Forcas? 1 (25 yes 2 □ No If Yas, Giva Yaar or Datas: WW II Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. Naver Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☐ Widowad 4 ☐ Divorced 15. Decedant's Education (Specify only highast grade completed) 16a. Dacadent's Usuel Occupation (Giva kind of work done during most of working iifa. DO NOT use ratired) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elamantary/Secondery (0-12) Engineer Town Government 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Thomas Roy Brookes, Hannah Tunis Munnikhuvsen 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Hannah T. G. Koziski - Niece 3321 Breidablik Dr., Wilmington, DE 19807 20b. Placa of Disposition (Nema of cematary, crematory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 XBurlal 2 Cremation 3 | Removal from State 4 Donation 5 DOINE St. Mary's Episcopal Cem. 11/4/97 | Emmorton, Maryland 22. Name and Addrass of Facility
Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 lied the daath. Do not entar tha moda of dylng, such as cardiec or respiretory errest, Immedieta Causa (Final 1 weck PNEUMONIA disaasa or condition rasulting in daath) Due to (or as a consequence of) Sequantially list conditions, if any, laading to Immadiata cause. Entar Undarfying Ceuse (Disaasa or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Discuse 1 Pres 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings svalleble prior to completion of cause of death? 24e. Wes an autopsy performed? Cerebrovascular Disease 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how Injury occurred 1 Yas 2 No

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28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29d. Data signad (Month, Day, Year)

November 1,1977

Physician /Medical Examiner

Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

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7 is marked other than "natural", or items 23a or traumatic event, the Madical Examiner must be r

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Baltimore,

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Division of Vital Records, P.O. Box 68760, Physician/Medical Completed Be 2 death. 24 hours after o

filled in by the funeral Certification: Diractor:

To the Hospital within 24 hours a To the Funeral Completely filled

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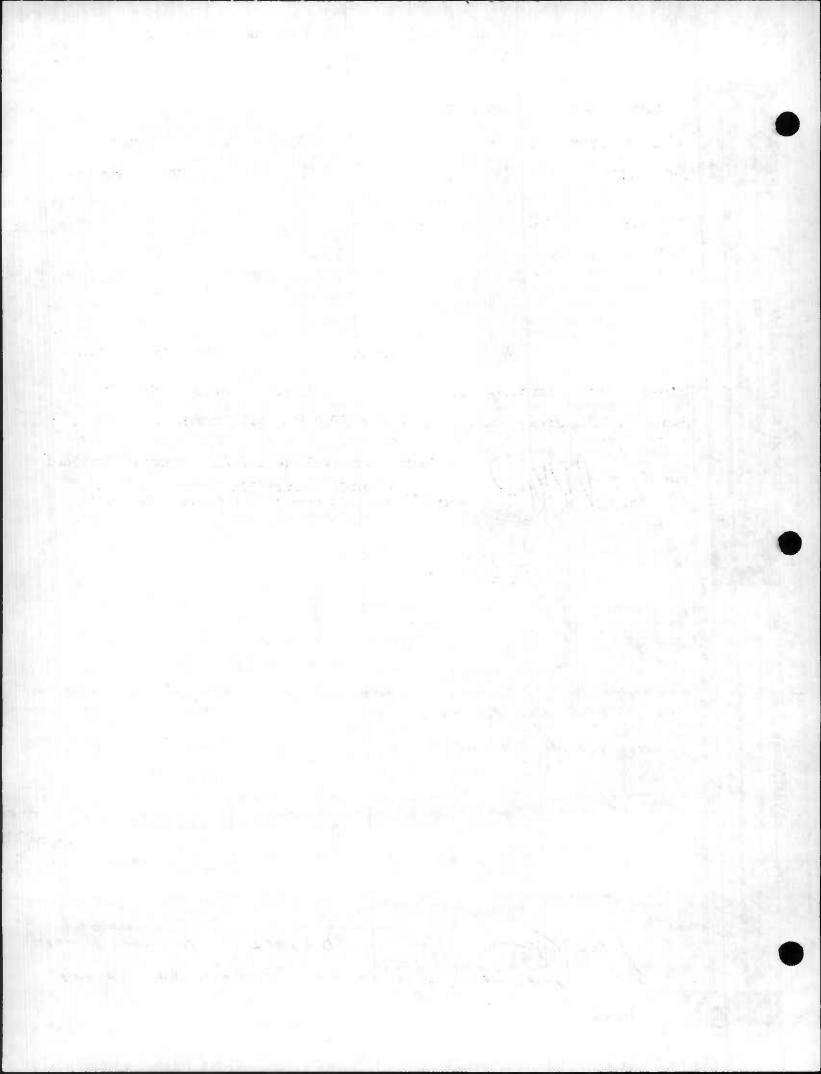
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, dete and place, and due to the causa(s) and manner stated. Medical 29a. Certifiar 29b. Signature end titla of certifiar

30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print) Kevin Cyach M.D. 31. Date filad (Month, Day, Year)

2 North Are. BelAir, Md. 32 Hegistrale Schatter Reveal

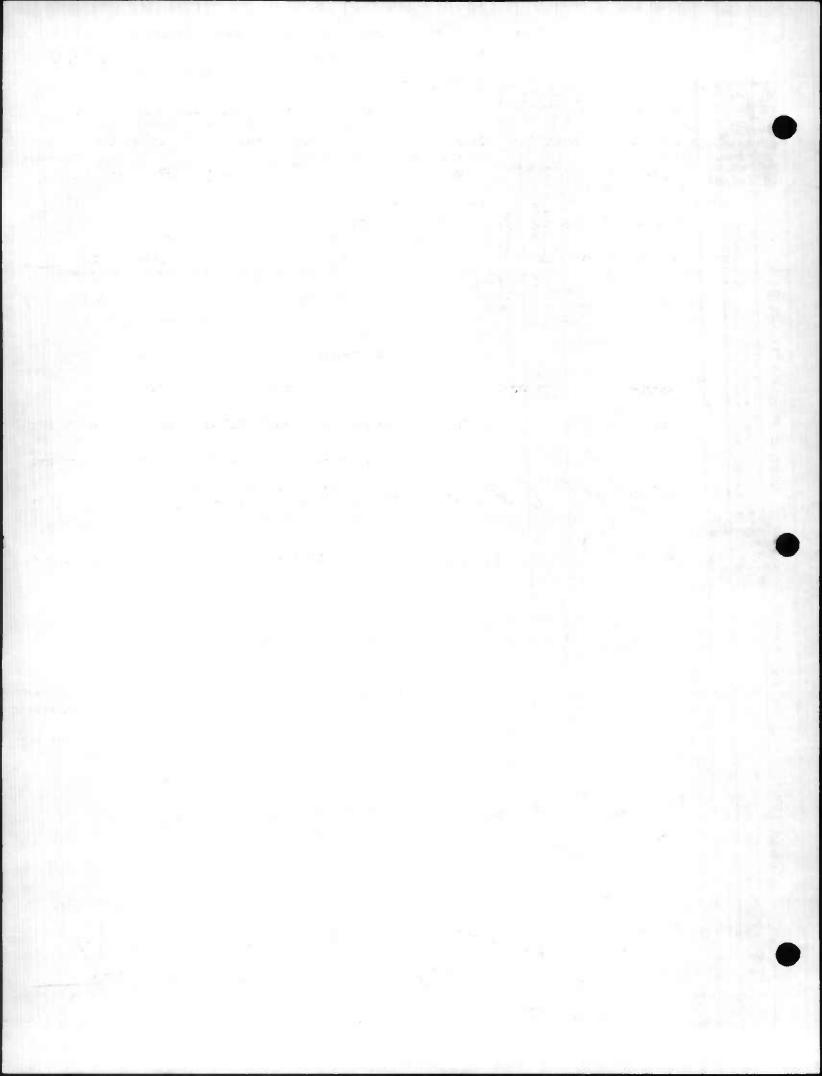
28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

State Registrar



State of Maryland / Department of Health and Mental Hygiene 7 35640

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E M		19a. Informent's Name/Ralationsh	Ip (Type, Print)		19b. Maili	ing Addra	ass (Street	end Number or F	ural Routa Num	per, City o	r Town,	Stata, Zip Coo	le)
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State of Maryland / Department of Health and Mental Hygiene 35641 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 27 Sascom ma November 8 1997 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Wilson Health Care Center Gaithersburg Montgomery 7. Age (In yrs. lest birthdey) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6 Sex Birthplece (State or Foreign Country) **Funeral** 1□M 2⊠F Deys 87 Yrs. 220-34-4670 Director Kansas Usual Residence of Deceden death with the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ₺ No Director Maryland Montgomery Gaithersburg 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 301 Russell Avenue 20877 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritet Stetus 14. Rece - American Indien. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or filer eny injury or other traumatic event. In a Mental or other traumatic event. Bleck, White, etc. 1 Never Memled 2 Memled Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 Herbert Bascom Caroline Not Available 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) C. Brian Carlin/ Attorney 4405 East-West Highway, #603, Bethesda, MD 20814 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Nov. 12, 1997 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Sociles Lice 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue MO0689 Bethesda, Maryland 20814-3501 BMW nese, or complications thet caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical immediate L use (Finei disease or condition resulting in deeth) mo Examiner Due to (or es a consequence of) Examiner nding physician and use as the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): certificate be execu P.O. Box 68760. Physician/Medical Due to (or es e consequence of): USB as signed by the aid be detached for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records, Ď 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 X No After this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; f. 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 2 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 5 Pending investigation 1 DNatural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Sulcide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and piace, and due to the cause(s) end menner steted. 29e. Certifier (Check only 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number November 10,1997 mD 07231 70 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Brookes Que Gaithersburg MP 20877

10-207

32. Registrer's Signeture

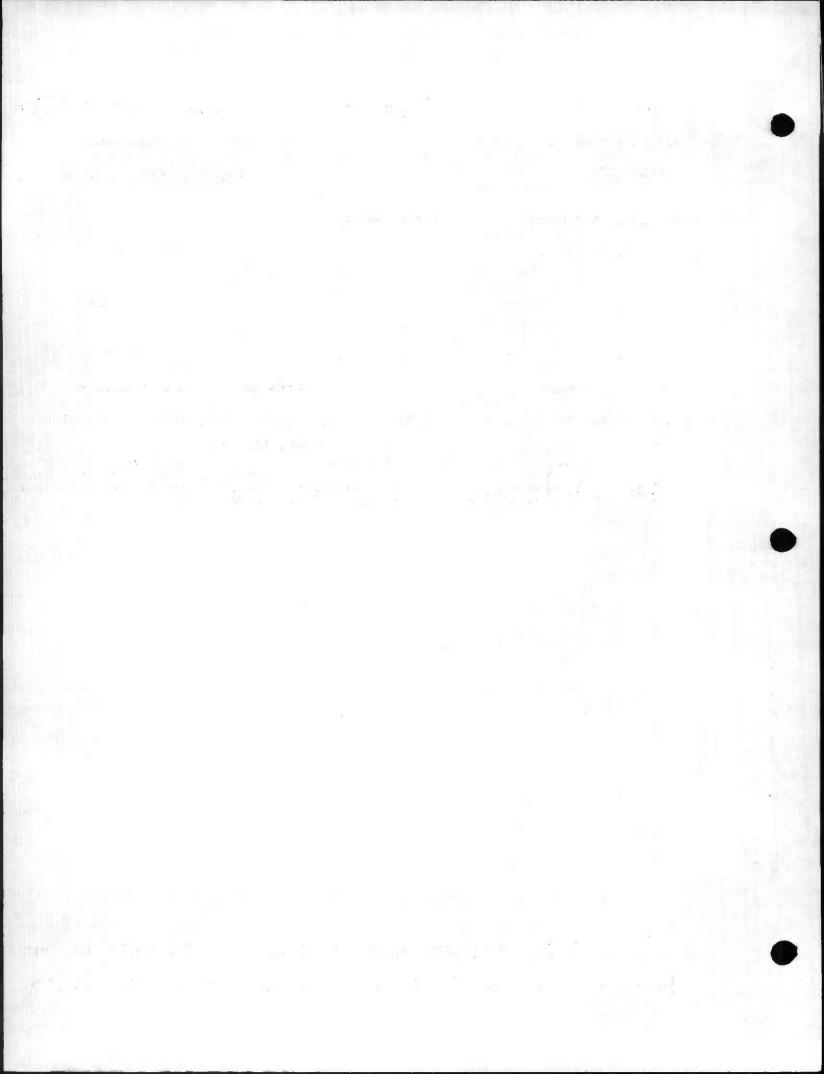
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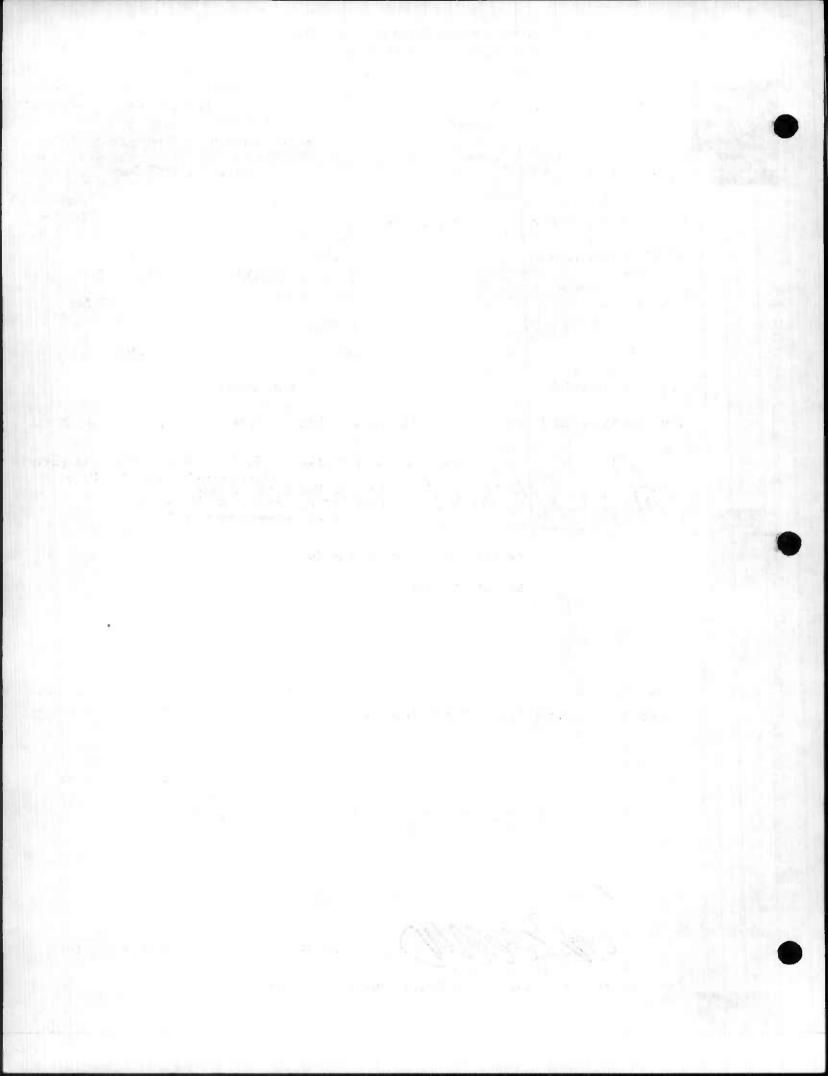
State Registrar

James R.D

31. Dete filed (Month, Dey, Year)

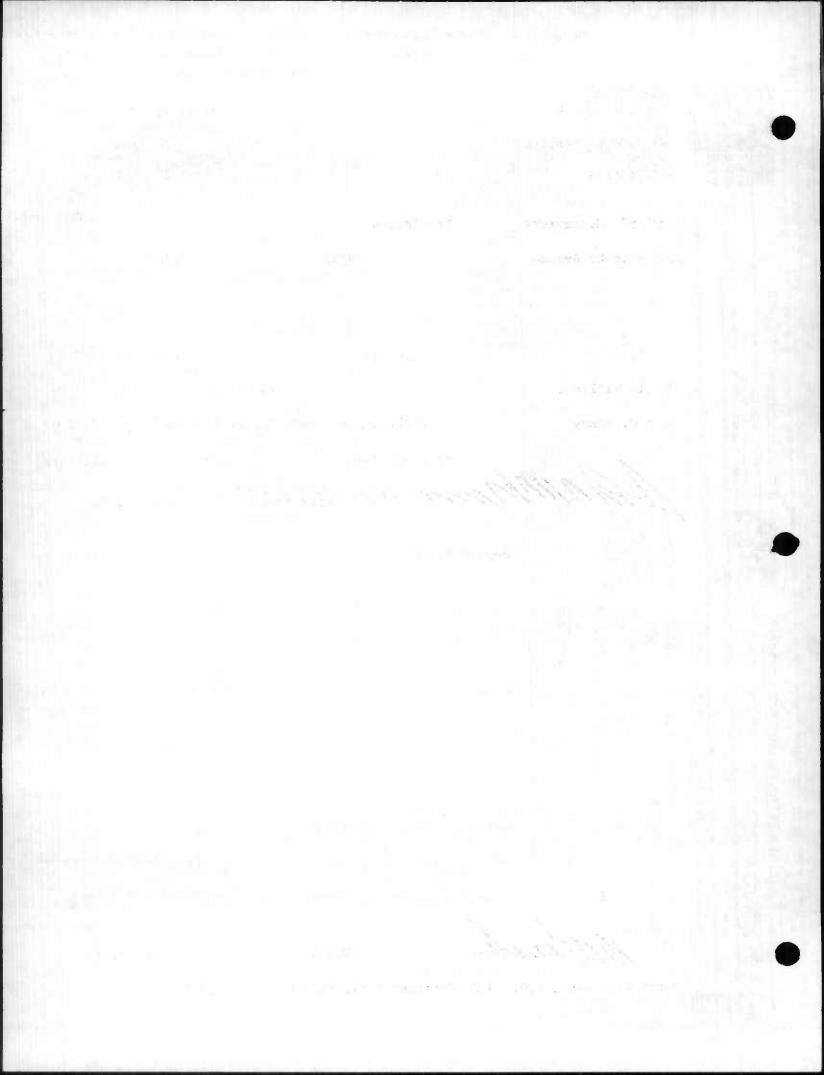


al Director	4e. Fecility Neme (If not Institution, given 12528 Epping Courts.) 5. Social Security Number 6. S	nkovich e street end num					4b. City. To	wn, or L	2. Dete of Do Month Novemb	er ll, l	Yeer 997	3. Time of 6	
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Director	12528 Epping Cour 5. Social Security Number 179-32-3225 Usuel Residence of Decedent	ex 7		T			4b. City. To	wn, or L	ocation of Deet	h 4c Count	of Dooth		J AM
al Director	5. Social Security Number 179-32-3225 Usuel Residence of Decedent	Sex 7									OI Deetii		
al Director	179-32-3225 Usuel Residence of Decedent						Silv	er S	Spring	Mont	gomei	y	
al Director	Usuel Residence of Decedent	☑ M 2□ F	. Age (In yrs. I	est birthday)	If Under		If Under	24 Hrs.	8 Date of Bi	rth	9. Birthpl	ece (Stete or	r Foreigi
al Director			97	Yrs.	Months	Deys	Hours	Min.	Oct. 2	2, 1900	Penns	ylvan:	ia
al Director	10a. State 10b. County												
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a Dire	Maryland Montgome	ry	Sil	ver Sp	oring							1 🗆 Yes	2 ₩ No
60	10e. Street end Number				10f. Zip	Code				10g. Citizen of	Whet Coun	try?	
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Funeral	11. Maritel Status	12. Wes Deced	ent Ever In U,	S. 13.	Wes Deced	dent of h	lispenic Orl	gin? (Sp	ecify Yes or No Rican, etc.))- 14. Rad	e - America		
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2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or De			ILI Yes	ZIZINO	Specify:			Specif	v: Wh	ite	
ted	15. Decedent's Ed (Specify only highest gra	fucetion		16e. Dece	dent's Usue	i Occup	etion	t of mode	la a	16b. Kind of B	usiness/Ind	ustry	
<u>d</u>	Elementery/Secondery (0-12)		for 5+)	life.	DO NOT us	se retire	d)	t OF WORK	ing				
5	12	4			Prie	st				Relig	jious		
Re	17. Fether's Neme (First, Middle, Last)						18. Mothe	er's Nam	e (First, Middle	, Melden Sumen	ne)		
0	John Bovankovich	1					Ma	ry I	Breza				
	19e. Informent's Name/Relationship (Type, Print)		19b. Meilir	ng Address	(Street	end Numb	er or Rur	al Route Numb	er, City or Town,	State, Zip	Code)	
	Paul Bovankovich	/ Son		12528	Eppi	ng (Court	, Si	lver Sp	ring, M	aryla	nd 20	906
	20a. Method of Disposition		00	eca of Dispo	sition (Nen	ne of	ce)		Dete	20c. Location	City or To	wn, Stete	
			919	_				1 1	/15/97	Unionto	wn. P	ennsv1	lvar
-			1				_						LVGI
	10x114 61	HALL	lan	// 1	1800	New	Hamps	hire	Avenu	e		Home	
-	23a Part Enter the disease or com	plications that on	UMU										
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1	Immediate Course /Final											Onsot ond D	OOIII
1	disease or condition	Meta	static	Cance	r to	the	lung				1		
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Xar	Sequentially list conditions,		Due to (or	es e consec	quenca of):								
	cause. Enter Underlying Ceuse (Diseese or Injury	C											
	thet initieted events resulting in deeth) Lest		Due to (or	es e conseq	uence of):								
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SIC	Pert II. Other eignificant conditions co	ontributing to dea	th but not resu	Iting In the u	nderlying c	ause giv	en in Pert I	, 1	23b. Did	tobacco use co	ntribute to	the cause of	f death
Ē	Anemia Arterio	sclarat	ic Hoar	t Dic	0250				10	Yes ZX No	3 Prob	ably 4 🗆 U	Inknow
2	Allemia, Alterio	SCIETOL	ic near	L DIS	ease								
9									24a. Wes	en eutopsy	24b. We	re autopsy fir	ndings
Die									pon	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	cor	npietlon of ca	IUSO
E									1□	Yes 2⊠No	1	Yes 281	No
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-	27. Menner of Deeth					'A	4 🗀 140	irsing Ho)	
	1 D2Neturei 5 ☐ Pending	(Month	Dey Yeer)	Injury				No	Log. Dogonbo	now injury coopi	100		
2	3 ☐ Suicide 6 ☐ Could not be		finium - At hor	ma form atr					2Rf Location (Street and Numl	or or Pure	Doute Numb	har
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State of Maryland / Department of Health and Mental Hygiene Q 7

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D09834 November 6, 19							D098	334	1	November	6, 1	997
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)	3	30. Name and addrass of person who	complated cause of	death (Item	n 23a) (Type,	Print)						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death A. ewis Collins 8:55 AM October 4a. Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Fallston Fallston Hartord General If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F 217-24-4091 60 Yrs. April 16, 1930 Battimore MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Harford 1 Yes 2 □ No Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 470 Sedgemore Ct. United States 12. Was Decedent Evar In U.S. Armed Forces? Was Dacedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Nas 2 No If Yes, Give Year or Dates: UNKnown 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Houne De Draftsman 12 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumame) Edmonds Lewis Charlotte collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) mary L. collins / wife 470 Sedgemore Ct. Edgewood, mD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of camerally, crematory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State Belain Memorial Park 10-29-91 Belair, mo 4 ☐ Donation 5 ☐ Other (Stepuly) 22. Name and Address of Facility Beard Funeral Home 21. Signature of Funeral Service Licens 522 Lewis St., Havre De Grace, MD 21078 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 Ominutes years Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last year 5 Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Diabetes Mellitus Chronic obstructive pulmonary 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? disease 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending Invastigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date algned (Month, Day, Year)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this : After this

Physician/Medical Be Completed by

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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items 23a

death

21215-0020

Baltimore, Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or ite

Department of Health a Important: if Item 27 is sny injury or other tra-

Physician /Medical

Examiner

Il Hygiene. other than "natural",

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Funeral

by

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other traumatic event, the Medical Examiner must be notified at

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and titla of certifian

Certification: To To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun Medical

10

State

Registrar

32. Registrar's Signatura

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NOV 7

Robert

6 Could not be determined

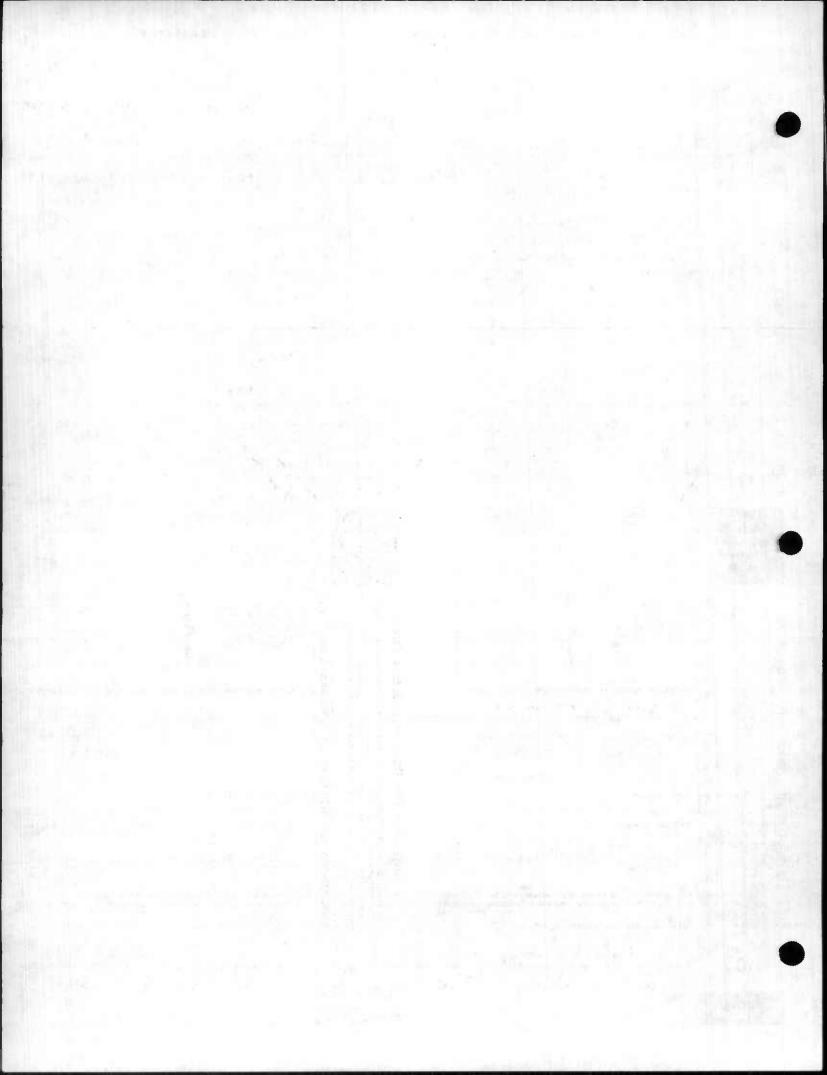
8530 Placsant Plains load, Baltmare, MD, 21286

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number



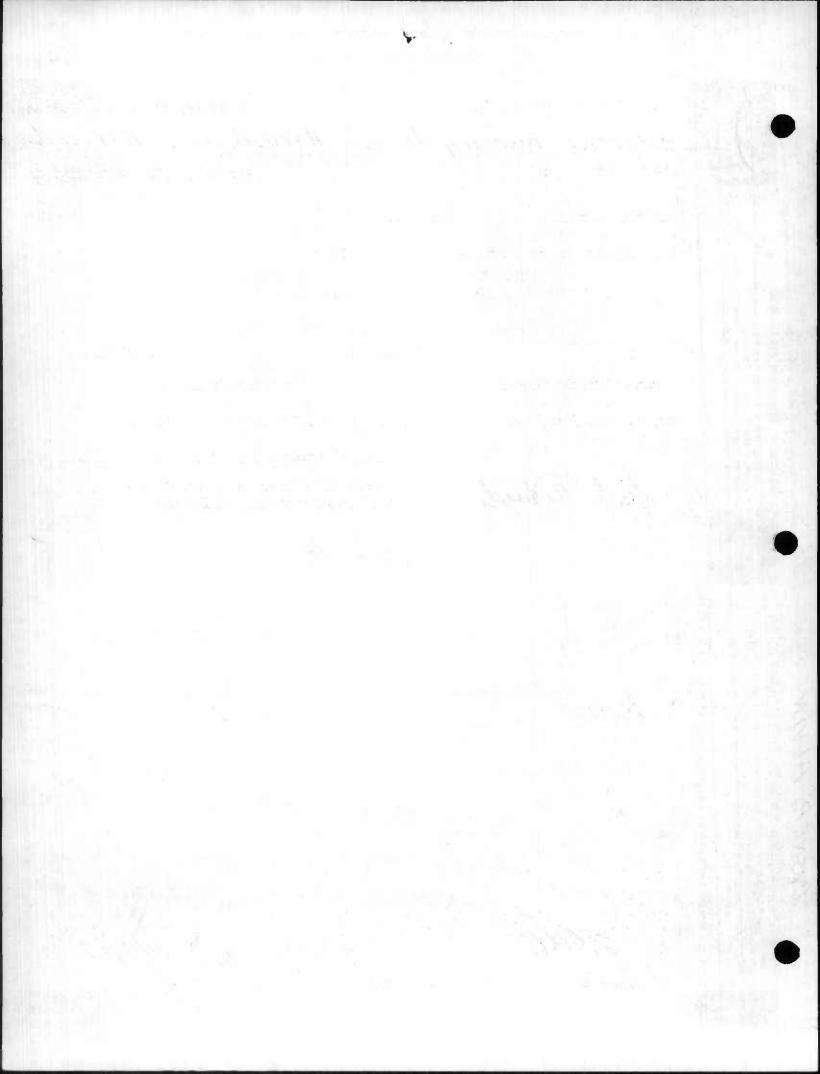
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death November 12 4b. City, Town, or Location of Death 4c. County of Death ck-Grace Havre Hart E H Under 1 Year 7. Aga (In yrs. last birthday) ff Under 24 Hrs. 1₽M 2□F Months Days 85 Yrs. West 10b. County 10c. City, Town or Location Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 21040 USA

Physician ALVIN LINCOLN COSNER, JR. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Sacurity Number Birthplace (State or Foreign Country) **Funeral** 214-18-6048 Director Usual Residence of Decedent with the Maryland 10a Stata 10d. Insida City Limits items 23a or 28a-f shoviner must be notified at 28a-f shov Maryland Director 1 ☐ Yas 2 ☐ No 10e. Street and Number 1616 Swallow Crest Drive, Apt. C Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, the Medical Examiner. Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 21215-0020 6 þ 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. int: If item 27 is marked other than Elementery/Secondary (0-12) College (1-4or 5+) Electrician Construction Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Abraham Lincoln Cosner Mary Etta Springer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) out of Heelth a. not: If Item 27 is r. V or oth. Mary E. Parks/Daughter P. O. Box 181, Darlington, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata ©Burial 2 ☐ Cremation 3 ☐ Removal from Stata permit. Page Depertment o Important: If any Injury or Harford Memorial Gardens 11/17/97 Aldino, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A. 21. Signature Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part I. E. of the disease, or complication of hat ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreshock, a heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medicai Immadiata Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Sequentially list conditions, if any, laading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, he attending physician led for use as the buria Physician/Medical Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the undarlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? After this certificate has been 1 Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica director, 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending investigation 1 Yes 2 No 2 Accident in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in Descritifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of on 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print) 1510100 32. Registrar's denature 31. Date filed (Month, Day, Year)

DHMH 16 Rav 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Jackson Gerard CARNEY, Sr. Nov. 12, 1997 8:55 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney, Mo
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) Montgomery If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1∏M 2□ F Yrs. 169-07-4631 Feb. 14, 1912 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3642 Glen Eagles Drive, Apt. 1-H 20906 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Inspection Supervisor Contract Inspector 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jackson Bruce Carney Isabel Jane Bricker 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackson G. Carney, II 80 Bryants Nursery Road, Silver Spring, MD 20905

20b. Place of Disposition (Name of cametery, crematory or other place)

Date

20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jefferson Memorial Park 11-15-97 Pittsburgh, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Batween Onset and Deeth 23e. Part1. Enter the disease, or complications thet caused the deeth. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arhers Due to (or as a consequence of) Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown article savere aprice stenosis 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Was an autopsy performed?

Physician /Medical Examiner

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26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

27. Menner of Death 1 PNaturel 2 Accident 3 Suicide

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Certification:

Medical

5 Pending investigation 6 Could not be determined

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281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of cortillor

29c. License number 28791

29d. Date signed (Month, Day, Year) November 13, 1997

State Registrar

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Loger Leonard, 3801 International Dr. Silver Spring my 20906 31. Date filed (Month, Day, Year)

(m)

32. Registrar's Signature

Funda Davidos - Rondall

Director

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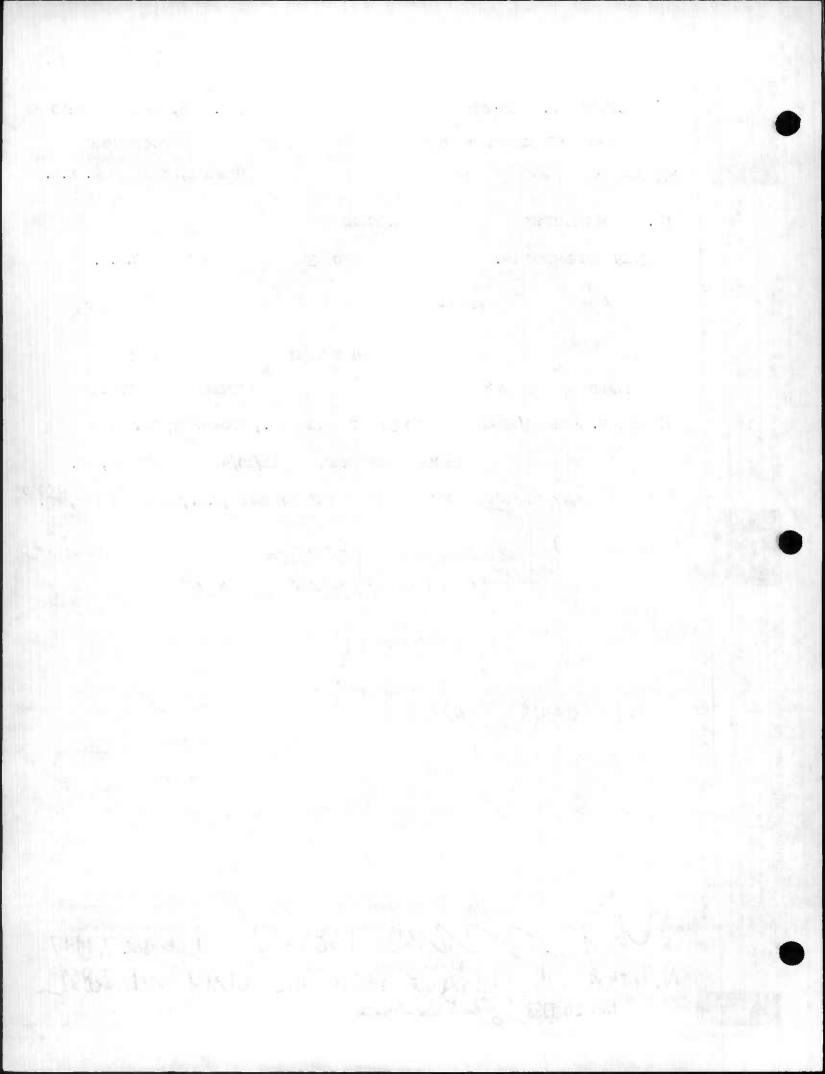
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State of Maryland / Department of Health and Mental Hygiene 9 7 35648

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Physicia /Medic		Guerche	n	Gre	egory	Cheb	chae	vit	ch		Nov. 1		997	Year	11:02	lom .
Examin		4a. Facility Neme (If not in							4b. City, To	wn, or Lo	ocation of Deat	h	c. County	of Death		
		8930 Harve	st Squ						Potoma				Mo	ontgo	mery	
Funeral		5. Social Security Number		Sex 10XM 2□F	7. Age (In y	rs. last birthde	/) If Unde Months	r 1 Yeer Deys		24 Hrs. Min.	8. Date of Bir (Month, Da July 1	th Ly, Yea	17)	9. Birthpl Count	ace (State or	Foreign
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ž		Usual Residence of Deced 10a. State 10b.	County		10c.	City, Town or	ocation							10	d. Inside City	v I lmits
natural", or items 23a or 28a-f show Sical Examiner must be notified at	ō	MD 1	Montgo	omerv		Poto									1 🗆 Yes	
28e	Director	10e. Street and Number		7		1000		p Code				100.0	litizen of V	Whet Count	n/2	
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jene. r than "naturel", or frems 23a or 28a-f show the Medical Examiner main be potified at	Funeral	11. Marital Status		12. Was Dece		U.S. 13				pin? (Sp	ecify Yes or No			e - America	n Indien.	
e de la composición della comp	Fur	1 Never Married 2	Married	Armed For			If Yes, spe	ecify Cub	en, Mexican	, Puerto	Rican, etc.)			k, White, e	itc.	
o, a	by	3 ∰Widowed 4 □ Di	vorced	If Yes, Give	e ites:		1 🗆 Yes	2 (3) 11 (b)	Specify:				Specify	, Whi	ce	
satur	Completed	15. De	cedent's E	ducation		16e. Dec	edent's Usu	al Occu	pation		VII.	16b.	Kind of Bu	alness/Ind	uatry	
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merked metic s	10				e				un	obta	ainable					
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Item 27 Other U			naevi	iten -su		Place of Dis			Squar	e Ct	. Poto					
		20a. Method of Disposition 1 Deurial 2 Crem	ation 3	Removal from S	inte	cemetery, cr	ematory or	other ple		İ	Date			City or To		
important: If any injury or 2008.		4 □ Donation 5 □ O		··.	K:						/12/97			Churc	ch, VA	
any Ir		21. Signature of Funeral S	er III Licer	nsee		F	dward	nd Addre	ess of Fecility	y nera	1 Dire	at i	าท			
2 0 0						1	091 R	ock	ille	Pike	Rockv	111	e. MD	2085	52	
		23e. Part1. Enter the dise shock, or heart failure	e, or com List only	piications that ca	used the de	eth. Do not e	nter the mod	de of dyi	ng, auch es	cardiec	or respiratory a	rrest.			Approximate Interval Betw	
sician															Onset end De	eath
edicai miner		Immediate Cause (Final disease or condition resulting in death)		a pel	ETAS	TATI	c /3	ROS	TAPE	. (ANC.	ER			5-X	15
	_	rooting in doziny			Due to	(or as a cons	equence of)	:								
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od for	Physician	Part It. Other significant c	onditions o	ontributing to dea	ath but not re	esulting in the	undertvino (cause of	ven in Part i		23b. Did	tobacc	O USA COL	ntribute to	the cause of	death?
signed by the atten d be deteched for u	'n							9.					2 🗆 No		ably 4 U	
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should t											24a. Wes	an aut		24b. We	re autopsy fin liable prior to	idings
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stor, p	Bec	25. Was case referred to n	nedical						28. Place	of Deet!	n (Check only o		7		7	
o ie	To	examiner? 1 ☐ Yes 2 ② No		Hospitel: 1 🗆 In	patient 2	☐ ER/Outpatio	ent 3 De	OA Ott	her:		me 5 Aesi		6 □Oth	er (Specify		
÷ @		27. Manner of Death	D 4!	28a. Date of	tnjury , Day Year)	28b. Time Injury	of a	28c. Inju			28d. Describe					
F. An	atic		Pending nvestigation		, Day roar,	Injury	М		Yes 2□N	10						
by ti	Certification:	3 ☐ Sulcide 6 ☐ 6 4 ☐ Homicide	Could not be determined	256. Place	of Injury - At g, etc. (Spec	home, farm, s	treet, factor	y, office			28f. Location (er or Rural	Route Numb	er,
ed i	Cer				g, oto. (opo						o., y o	, 010	,			
To the Funeral Direct completely filled in by	edical	29a. Certifier 12 Ce	ertifying Ph	yaician: To the bas	est of my kr	nowledge, des	th occurred	et the ti	me, date and	place,	end due to the	cause(s) and ma	nner as sta	ited.	
To the Funeral Director: After completely filled in by the funer	-	one)		and manne	er stated.	Tation and of t	IV 05 (I QA (I OF)	i, iti iliy c	pinon, deal	n occur	ed at the time,	date e	nd place, i	and due to	me cause(s)	
2 8	Σ	29b. Signeture and title of	ertifier	1 1	1		29	c. Licens	se number			29d. D	ate signed	i (Month, E	ley, Year)	
/		Plenne	ell	sold	The	~ M(DI	7211			_/(11119	77		
		30. Name and address of p														
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State		31. Date filed (Month, Day,	rear)	32. Re	gistear's Sig	Davidser-	Danie a	2								
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State of Maryland / Department of Health and Mental Hygiene

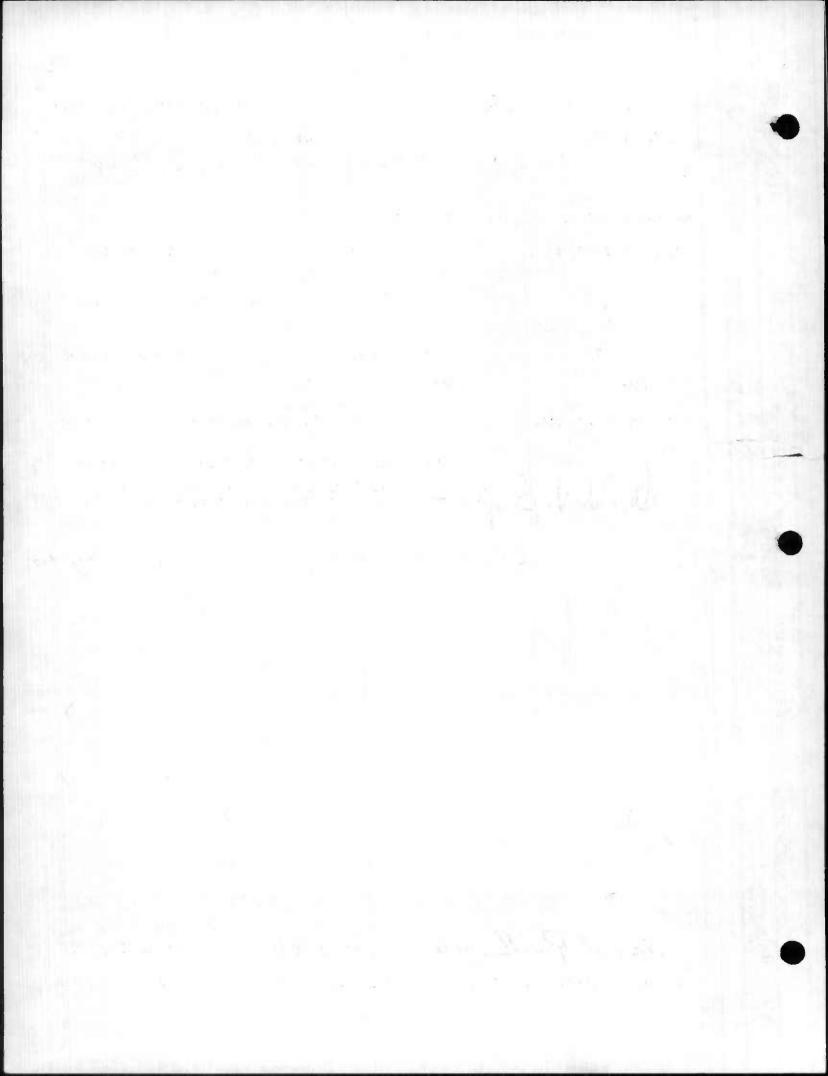
Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death r 10,1997 **Physician** November D Dolores A . Colon 1:00A. /Medicai 4a. Facility Nama (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Daath Examiner 22 Ridge Road Prince George's Greenbelt. 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) Dec. 10, 1919 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M XXF 092-22-5964 Yrs Director Puerto Rico Usual Rasidanca of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified at Maryland Prince George's Director XXYas 2□No Greenbelt 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? ò 22 Ridge Road, #216 20770 United States 230 items 2 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 X Yoo If Yas, Giva Yaar or Datas: 11. Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. The Medical Examiner 1 □ Navar Married 2 □ Married 6 1XX as 2□No Specify: Puerto Rican Baltimore, Maryland 21215-0020 Specify: by White 3 Widowad WDivorced "natural", Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health and Mentel Hyglene. Important: If Iswa 27 Is marked other than ** any fijury or other traumatic event, the Med police. Eiamantary/Sacondary (0-12) Collaga (1-4or 5+) 12 Seamstress Clothing Manufacturer 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Clemente Alicea Dolores Nunez 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Eve Murphy (Daughter) 4914-8 Columbia Road Columbia, Maryland 21044 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata XX Burial 2 Cramation 3 Ramoval from Stata ation 5 Othar (Spacify) Gate of Heaven Cemetery 11/12/1997 Silver Spring, Md. 21. Signatura of Funaral Servica Licensae 22. Nama and Addrass of Facility Donald V. Borgwardt Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that it is sad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on laur 1 line. 4400 Powder Mill Road Beltsville, Maryland 20705 Approximata Intarval Batw Onsat and Death Physician /Medicai Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner physician end s the buriel-transit certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiatad avants rasulting in daath) Last Dua to (or as a consequanca of) 68760, Physician/Medical Dua to (or as a consaquance of): for use es Box P.O. ed by the e Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The law requires that signed b Records, by 24b. Wara autopsy findings available prior to complation of cause of daath? Be Completed 24a. Was an autopsy performed? ate hes 1 ☐ Yas 2 No 1 ☐ Yas 20 CNo certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, t 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) axaminar? 1□ Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 🗷 Rasidance 6 ☐ Othar (Spacify) Certification: To 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Naturaf 5 Panding 1 Yas 2 No invastigation 2 Accidant 3 Suicida 6 Could not be datamined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

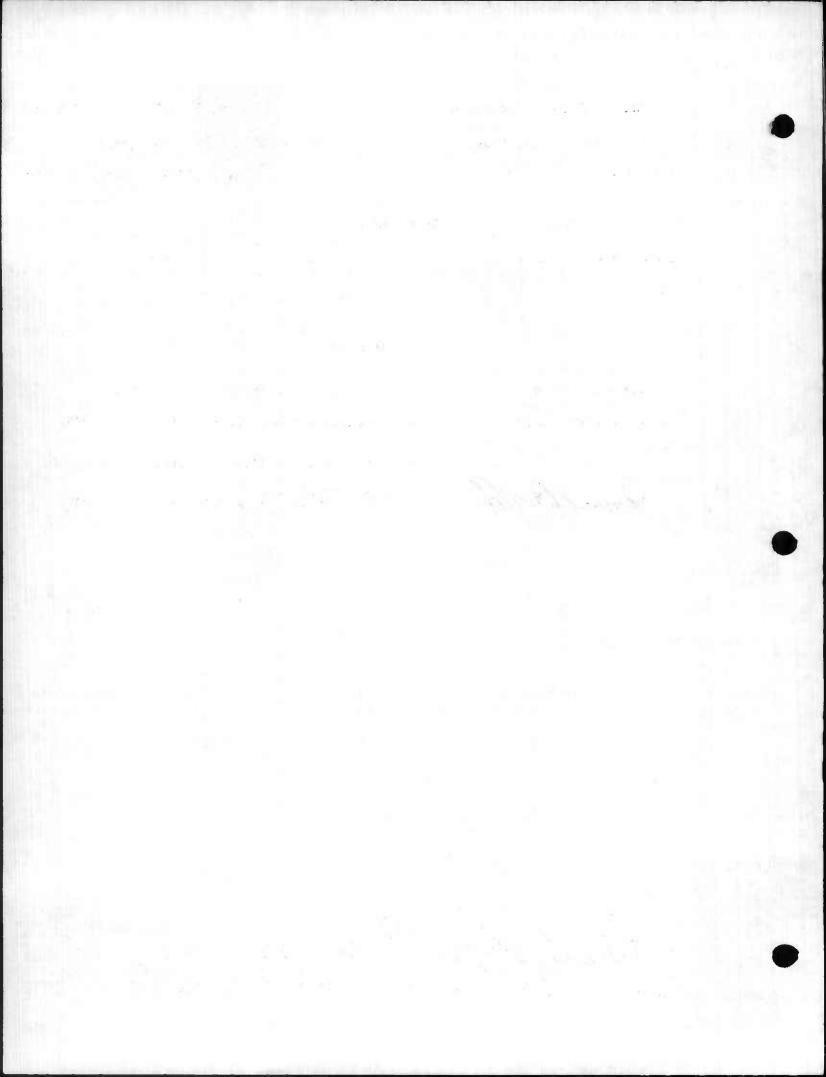
Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medicai 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) November 10, 1997 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Daniel Rosenblum, M.D. 10400 Connecticut Ave., #606 Kensington, Maryland 20895 31. Data filed (Month, Day, Year) NOV 12 1997 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar



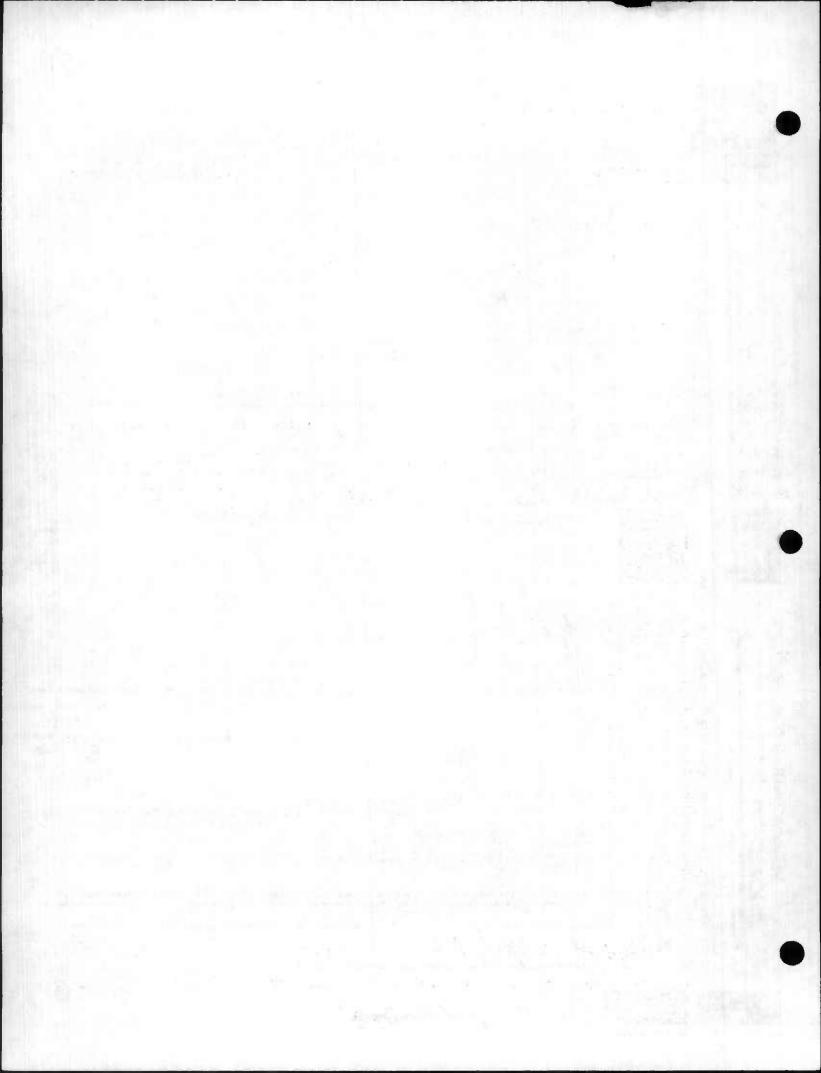
				Certificate o		Mental Hygi	g. No.	35650
		1. Decedent's Nema (First, Middla, Last)				2. Deta of Deeth Month		3. Time of Death
Physici /Medi		Dona Belle Coste	11o			Nov. 9,		10:00 A.M
Examir		4a. Fecility Neme (If not institution, give street and number)		4b. City, Town, or	Location of Death	4c. County of	Deeth
<u> </u>		Manor Care- Chevy Chas	e		Chevy Ch		Montgo	omery
Funeral		1 M 2 TE	ga (In yrs. lest	Months Day		(Month, Dey,	Year) 9	Birthpleca (Stata or Foreign Country)
Director	1	578-62-5823 Usual Residence of Decedent	93	Yrs.		May 10,1	904	Massachusetts
A 10		10a. Stata 10b. County	10c. City, To	own or Location				10d. Insida City Limits
ral", or items 23a or 28a-f show Examiner must be notified at	ğ	Md. Montgomery	Che	evy Chase				1 ☑ Yes 2 ☐ No
1 28e	Funeral Director	10e. Street end Number	GII	10f. Zlp Code		10	g. Citizen of Who	at Country?
38 0	0	8700 Jones Mill Road			20815		U.S.A.	
E E	ner	11. Marital Status 12. Was Decedent	Ever in U,S.	13. Wes Decedent of If Yes, specify Cu		Specify Yes or No-	14. Race -	American Indien,
or its	3	Armed Forces 1 ☑ Never Merried 2 ☐ Married 1 ☐ Yas 2 ☑ If Yes, Give		1 Yes 2⊠N		to Hicen, etc.)		White, etc.
4	1 by	3 ☐ Widowed 4 ☐ Divorced Yeer or Detes:		10 162 2614	о эреспу:		Specify:	white
end Mental Hygiene. Is marked other than "natural", or sumatic svent, the Medical Exerci-	Completed by	15. Decedent's Education (Specify only highest grede completed)	10	Sa. Decedent's Usuel Occ (Give kind of work don life. DO NOT use reti	upetion e during most of wa	rking 1	6b. Kind of Busin	ness/Industry
han .	dw	Elementery/Secondery (0-12) Collega (1-4or	5+)	life. DO NOT use reti Secretary	red)		Catholic	Church
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f Haalth end Mental Hygiene. Itsm 27 is marked other than other treumatic svent, the Ma		Suzanne Graham/cousin		.0400 Rockvi				
itsm 27 itsm cother tr		20a. Method of Disposition		ot Disposition (Neme of tery, cremetory or other p				ty or Town, Steta
int: If its		□ Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)			1	1 07	C41 (O MD
들은		21. Signature Trunerel Service Licenses	Gate	of Heaven C		1,9/	Silver S	Spring, MD.
Deparimpor		· () and o(1)	7	DeVol Fun	eral Home			
		23a Fary Enter the diseasa, or complications that cause	d the death T	2222 Wisc	onsin Ave	.,Washing	ton, D.(
laian		book, or heert teilure. List only one ceuse on each	ine.		ying, odon as cardio	o or respiratory erre	ot,	Approximate Interval Between Onsat and Death
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aminer		disease or condition resulting in deeth)	PHIL	D/AL a consequence of):	INF	ARCI	100	2 MONTHS
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fler	on:	27. Manner of Deeth 1 □ Neturel 5 □ Pending (Month, De	by Year) 28t		ork?	28d. Describe hor	w Injury occurred	
death.	cati	25 Accident Investigation SEPT 3	097	//	Yes 2 10 No	TELL		
arrer deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of In building, e	jury - At home, ic. <i>(Specify)</i>	ferm, street, fectory, offic	Ө	28f. Location (Str. City or Town,		or Rural Route Number,
rai Delli				HOME		#10		
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within 24 hours after To the Funeral Direct completely filled in by	Med	one) and manner si 29b. Signatura end fille of cardifier	eted.	0	nse number			
	-	200. Signatura and man or commer	.11	29C. LICO	M A C	29	Julia signed (/	Month, Day, Year)
-		" Hucel fill	ull	00	+049	^	10V 10	4+
		30. Neme end eddress of person who completed cause	deeth (Item 23	(Type, Print)	1 R1 2	5-116	x. 1/1/2	2004
		TRANCIS MAYRE	10215	LE KNWOS	0110 0	8/146-1	MINO	20017
Sta Registr		31. Dete filed (Month, Dey, Year) 32. Regist NOV 14 1997	rer's Signeture	n-Randelle				



State of Maryland / Department of Health and Mental Hygiene 97 3565

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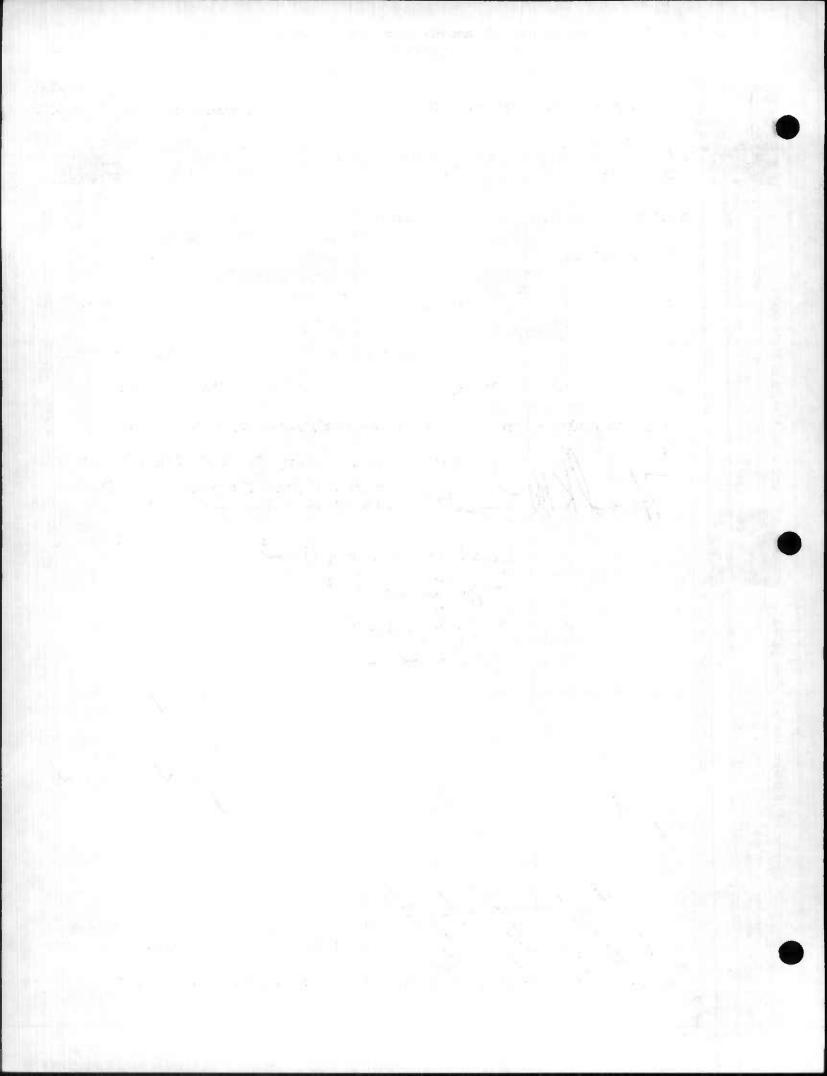
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State of Maryland / Department of Health and Mental Hygiene 7 3 5 6 5 2

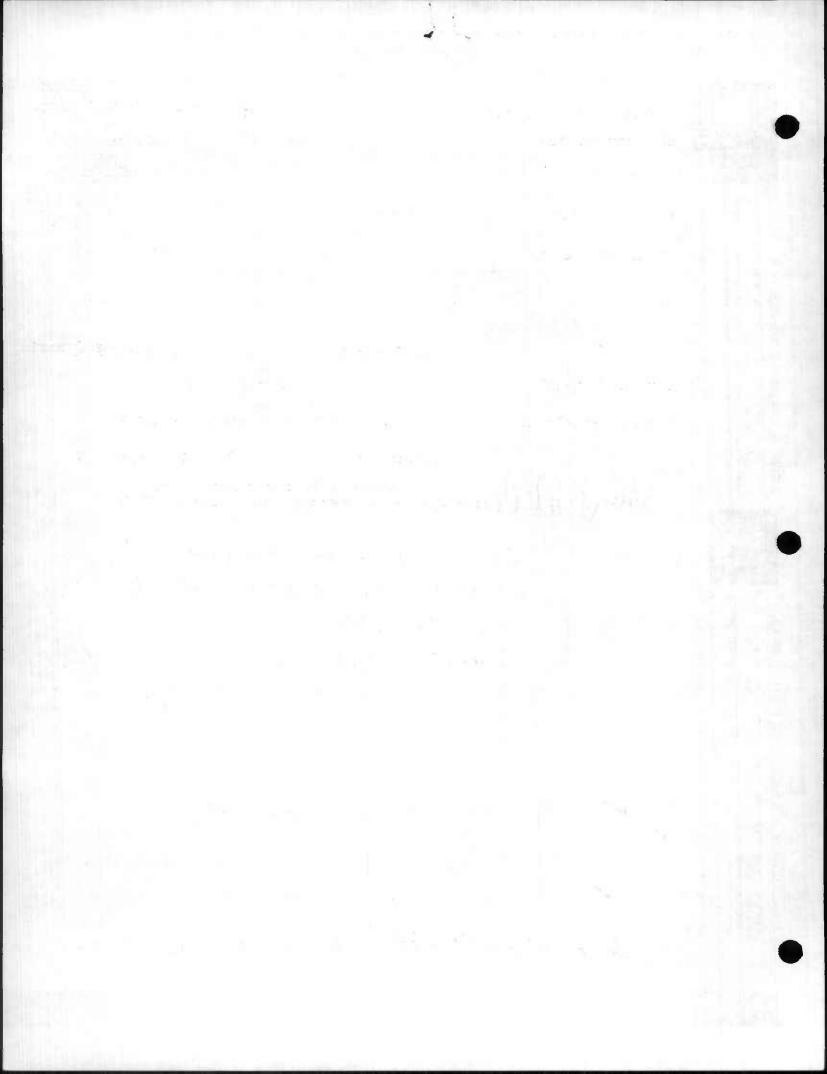
					Certificate of	Death		Reg. No.		
		1. Decedent's Name (First, Middle, L.	est)				2. Date of Dea	ath	Same 10	3. Time of Death
	ician	WALTER MOR	RIS DONLE	Y, SR.			Novembe	er 9, 19	Year 997	3:00 PM
	dical niner	4a. Facility Name (If not institution, gi				4b. City, Town,	or Location of Death	4c. Count		3:00 PM
Exal	mner	103 Singer Rd.	Service acons							-2
			Sex 7. Aq	e (In yrs. last birt	hday) If Under 1 Year	Abino			Harfor	
Funer Direct			1 2 M 2□ F		Yrs. Months Days		in. (Month, Da	v, Year)		lace (State or Foreign try)
Direct	OF-	215-09-2730 Usual Residence of Decedent		13			May 3,	1918	Mary	yland
and w		10a. State 10b. County		10c. City, Town	or Location				10	0d. Inside City Limits
Aary e b	٥	Maryland Harf	ord	7	bingdon					1 ☐ Yes 230 No
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21215-0020 d within 72 hours af giene. br than "naturel", or in the Wad call Exem.	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done	pation during most of a	working	16b. Kind of B	usiness/Ind	lustry
within one.	g	Elementary/Secondery (0-12)	College (1-4or 5	+)	(Give kind of work done life. DO NOT use retire					
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C 0 = 0 >	Be	17. Fathar's Name (First, Middle, Last				18. Mother's N	lame (First, Middle,	Maiden Sumer	ne)	
hould be de Mentel marked of matic ev	To	Morris (nmn)	Don	ley		Sadie	Dor	a	Steve	ns
Marylc d 2 should th end Mer T Is marks traumatic	ľ	19e, Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Street	and Number or	Rurel Route Numbe	r, City or Town	, Stata, Zip	Coda)
		William G. Donley	z - Son		04 Snow Roa				21040	
baltimore, permit. Peges 1 en Department of Healt Important: If Item 2 any Injury or other		20a. Method of Disposition		20b. Place of	Disposition (Name of		Date	20c. Location		
Sattimore, Semit. Peges 1 e Department of Hee mportant: If Item any Injury or othe		Buriel 2 Cremation 3	Removal from State		y, crematory or other pla	•	111 10 00			
t. P.		4 Donation 5 Other Speci		Cokesb	ury U.M. Ce		11-12-97	Abing	don,	Maryland
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	9	Hava K.	IXI and	100	1317 Coke	chury P	ahina	don MD		
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/Medica		Immediate Cause (Final	(00	Diam.	0	ansi	*			
Examine	er	disease or condition resulting in death)		aurju	andnasu	Moon	,		-	
	ē e		(Day	Due to (or as a o	orisequence of					
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	- Le	_			_					
. p . p	Physician	Part II. Other significent conditions	contributing to death bu	it not resulting In	the underlying ceuse gi	ven in Pert I.	23b. Did t	obecco use go	ntribute to	the cause of death?
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v requiras been sign should be								an autopsy	24b. We	re autopsy findings
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OT VITAI RECORDS, Physicien: The law requires t this certificate has been signs this certificate has been signs tai director, page 2 should be	Be	25. Was casa referred to medical examiner?	11-2-2				Death (Check ofly o	ne)		
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	Ë	27. Manyler of Death 1 Maturel 5 Pending	28a. Date of Injur (Month, Day		ime of 28c. Inju	ry at rk?	28d. Describe h	ow Injury occur	red	
ttendin death. ctor: Af	atic	2 Accident Investigation				Yes 2 □ No				
or Attending offer death. Director: After din by the fune	ertification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, far	m, street, factory, office	è	28f. Location (S		ber or Rural	Route Number,
5 6 5 E	ert	4 nomicide	building, etc	. (Specify)			City or Tow	n, State)		
spite ours	O C	29a. Certifier 1 Certifying Pt	vsician: To the best o	f my knawledge	deals occurred at the th	me date and nia	ice and due to the	ause/s) and m	anner as st	hete
To the Hospital or within 24 hours effect To the Funeral Dir completaly filled in	edicai	(Check mily 2 Medical Fire	niner: On the basis of	exemination and	death occurred at the the	pinlon, death oc	curred at the time,	ate and plece,	and due to	the cause(s)
ithin of the complete of the c	Σ	29b. Signature and title of Septier		177	29c, Licens	se number	T.	29d. Date signe	d (Month, I	Dav. Year)
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841			completed cause of the							
		Henry M. Scagl	ola, 9712	Belair 1	Rd., Suite	301, Ba	ltimore,	Md. 21	236	
5	State	31. Date filed (Month, Day, Year) 13	7 32. Registra	rs Signature	rdall					
Regis	strar	WOAT TO 19	01		- *- *					



					Cer	rtificate of	Death		g. No.		
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inerai ector		200-26-9830 Usuel Residence of Decedent	1M2 M 2□ F	65	Yrs.	Months Days			7 13,	Cour	plece (Stata or Foreigntry) New York
=		10a. Stete 10b. County		10c. Cit	ty, Town or Lo	cation				1	I0d. Inelde City Limit
iner must be notified at	to	Maryland Harfor	rd		Edgewo	ood					1 ☐ Yes 210 N
Jour	Director	10e. Street end Number				10f. Zip Code		10	g. Citizen of	Whet Cour	ntry?
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F	dby	3 ☑ Widowed 4 ☐ Divorced	Yeer or Date	s: 19!	55	25/10	ореспу.		Spec	ny: VVII.	ite
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	Physician/M	Pert II. Other significant condition	confributing to death	buf not res	ulting In the un	nderlylng ceuse gi	iven in Pert t.	23b. Did tol	acco use c	ontribute to	the cause of death
	Phy							1 🗆 Ye	2 DNo	3□ Pro	bably 4 Unknow
	þ		0.00							T	
	Completed							24a. Wes er perform	eutopsy ed?	av	era eutopsy findings allabla prior to
	pje									of	mpletion of ceuse deeth?
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	Be (25. Wes casa referred to madicel exeminar?					28. Place of De	eeth (Check only one)		
	2	1 Yes 2 No	Hospitel: 1 🗆 Inpa	itient 2 🗆	ER/Outpetien	t 3 DOA	har: 4□ Nursing	Home 5 Resida	nce 6 🗆 O	ther (Specif	(y)
		27. Manner of Deeth 1 ■ Naturel 5 □ Pending	28e. Dete of in (Month, I	njury Day Year)	28b. Time of Injury	28c. tnju Wo	ry et ork?	28d. Describe ho	w injury occu	rred	
funeral	cati	2 ☐ Accident Investiga	N. C.			M 1	Yes 2□No				
	=	3 Sulcide 6 Could no determin	ad 286. Piece of	Injury - At ho	ome, ferm, sfre	eaf, factory, office		28f. Location (Str City or Town		ber or Rura	al Route Number,
	E										
	Certification:							1			
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completely lifted in by the Tuneral director, page	Medical Certi	29a. Certifiar (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis end menner	of axamina	wiedge, deetb tion end/or id	occurred at the ti	opinion, deeth occ	curred et the time, da	use(s) end n te end place	, and due to	o tha causa(s)

State Registrar 31. Date filed (Month, Day, Year) 1997 32 Fedestriff Selem Reviell

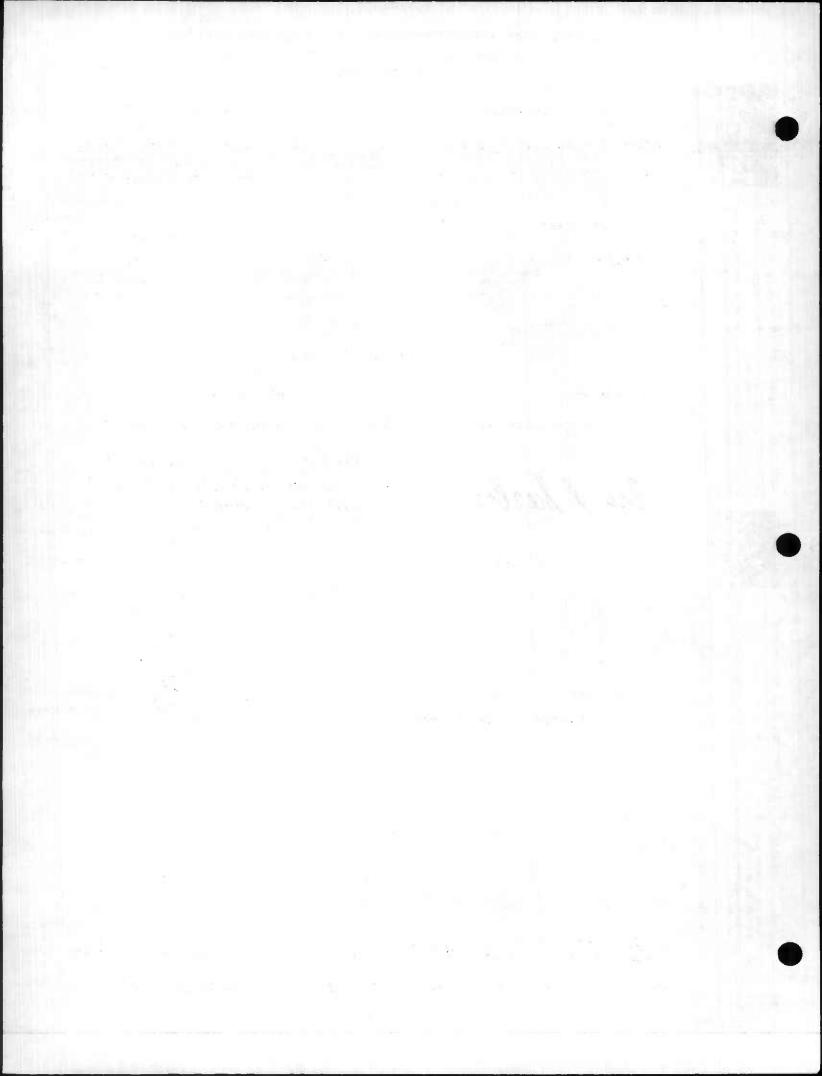
30. Nema end address of parson who complated causa of deeth (item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 97 35654

Certificate of Death

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	Physic /Medi			engowski							er 6, 19	Yaar 197	3. Tima of Death 4:15 A
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	Aaryland f show	or	10a. Stata 10b. County		10c. City, T							10	0d. Insida City Limits 1 ☐ Yes 2 ② No
	1 28a	Director	MD Montgome	ery	Ro	ckvil	Le 10f. Zip	Coda			10g. Citizan of	What Count	try?
	th with	ai Di	5312 Water Whee	el Court				208	355		U	SA	
020	2 should be filed within 72 hours efter death with the Maryland and Mental hygiene. Is marked other than "natural", or items 23s or 28s-f show sumstic event, the Medical Exercites must be rectified as	by Funeral	11. Marital Status 1 □ Nevar Marriad 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedant Armed Forcas' 1 ☐ Yas 2 ☑ If Yas, Giva Yeer or Datas:	?				Hispenic Origin? pan, Maxican, Pue Spacify:	(Specify Yes or Norto Rican, atc.)		ce - Amarica ck, White, a y: Whi	atc.
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Baltimore,			20a. Mathod of Disposition 1 🖾 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Speci	Ramoval from Stata	20b. Plac	a of Dispos atary, cram	sition (Nan	na <i>of</i> thar pla	aca)	Data 11/10/97	20c. Location	City or Tox	wn, Stete
Balti	permit. Page: Department of Important: If I any injury or once.		21. Signatura of Funaral Sarvice trice		,	22. Ho	Nema en	d Addr	ass of Facility 500 Ut	Francis . niversit	J. Colli	ns Fu	neral
	Physician /Medical		23a. Part1. Entar the disaasa, or con shock, or haart failura. List only Immediata Causa (Final			Do not ante	IVET	Spr a of dy	ing, MD Ing, such as cerd	20901 ac or raspiratory a	rrast,		Approximata Intarval Batwean Onsel and Death
	Examiner		disease or condition rasulting in death)	a. Anem	ia Dua to (or as	s a consequ	uanca ot).					-	years
	D #	lner		Gast	rointe			eedi	ng				vears
90,	oe axecute clan and xurial-trans	I Examiner	Saquantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	0.	Dua to (or as	a consequ	uance ot):						
ox 68760,	n certificate be assocuted anding physician and use as the burial-transit	Physician/Medical	that initiated avants rasulting in death) Last	d	Due to (or as	a consequ	uanca of):						
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s, P.O	requires thet the death ween signed by the atter hould be detached for u	by Phys	Pagets Disea		oporos:			4034 g			Yes 2⊠ No		ebly 4 Unknown
Records	aw ls t	Completed b									an eutopsy ormed?	ave	ra autopsy findings iliabla prior to npletion of causa laath?
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Division	Attending F or death. ector: After by the funer	Certification:	1 ⊠Naturai 5 ☐ PandIng 2 ☐ Accidant invastigatio 3 ☐ Suicida 6 ☐ Could not b	(Month, Da	ny Year)	Injury	М		ork?]Yas 2□No				Conta Number
<u>></u>	To the Hospital or Attent within 24 hours efter deat To the Funeral Director: completely filled in by the		4 Homicida datarminad	building, at	ic. (Spacify)					City or To	Street and Numi wn, Stata)		
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	within To the	Me	29b. Signature and titla of certifiar	0			290	. Licen	sa number		29d. Deta signe	d (Month, L	Day, Year)
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			PAUL A. SILVER,					E #	280 SILV	ER SPRIN	G.MARYI	AND 20	1901
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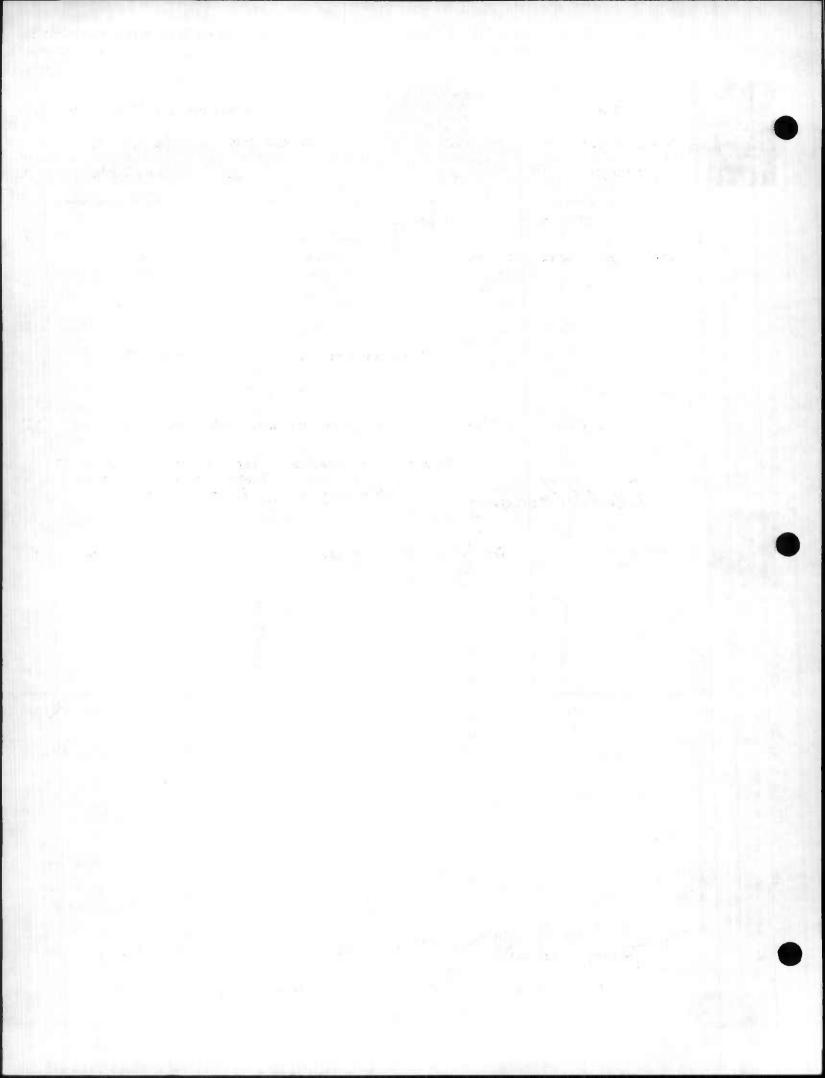


State of Maryland / Department of Health and Mental Hygiene 9 7

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 5:05 p.m. John V. Dorr Jr. November 10, 1997 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Washington Adventist Hospital Takoma Park Montgomery Hours Min. 8. Dete of Birth (Month, Day, Ye. April 20, 5. Social Security Number If Under 1 Year 9. Birthplece (State or Foreign Country) 1941 Washington, DC 7. Age (In yrs. lest birthday) **Funeral** Deys Months 1⊠M 2□ F 56 220-38-4594 Director Usuel Residence of Decedent the Manyland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other treumstic event, the Medical Examiner must be notflied at Director 1 Yes 2 No Montgomery Takoma Park 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 6 items 23a 7667 Maple Avenue Apt. #902 20912 USA death Funeral Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hydiene. Important: If fem 27 is marked other than "natural", or file any injury or other treumetic event, the Next at Evantmen I ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Paint Contractor Self Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be John V. Dorr 2 Julia Miller 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Darlene F. Dorr (wife) 7667 Maple Avenue Apt. #902, Takoma Park, MD 20912 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 11/13/97 Silver Spring, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Francis J. Collins Funeral 500 University Blvd. West Home, Inc. (amser 20 per Silver Spring, MD 20901 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Betw Onset end Deeth **Physician** /Medical Immediate Cause (Final Coronary artery disease Two years diseese or condition resulting in death) Examiner Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest and Due to (or es e consequence of): Records, P.O. Box 68760, attending physician for use as the buria certificate be Physician/Medical Due to (or es a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the the signed by 1 Yes 2 No 3 Probably 4 Unknown ģ 9 Completed 24b. Were autopsy findings aveileble prior to 24e. Wes an autopsy performed? peen completion of cause of death? page 2 certificate has 1 ☐ Yes 2 ☐ No Division of Vital director, Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Deeth To the Hospital or Attending Physicial 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

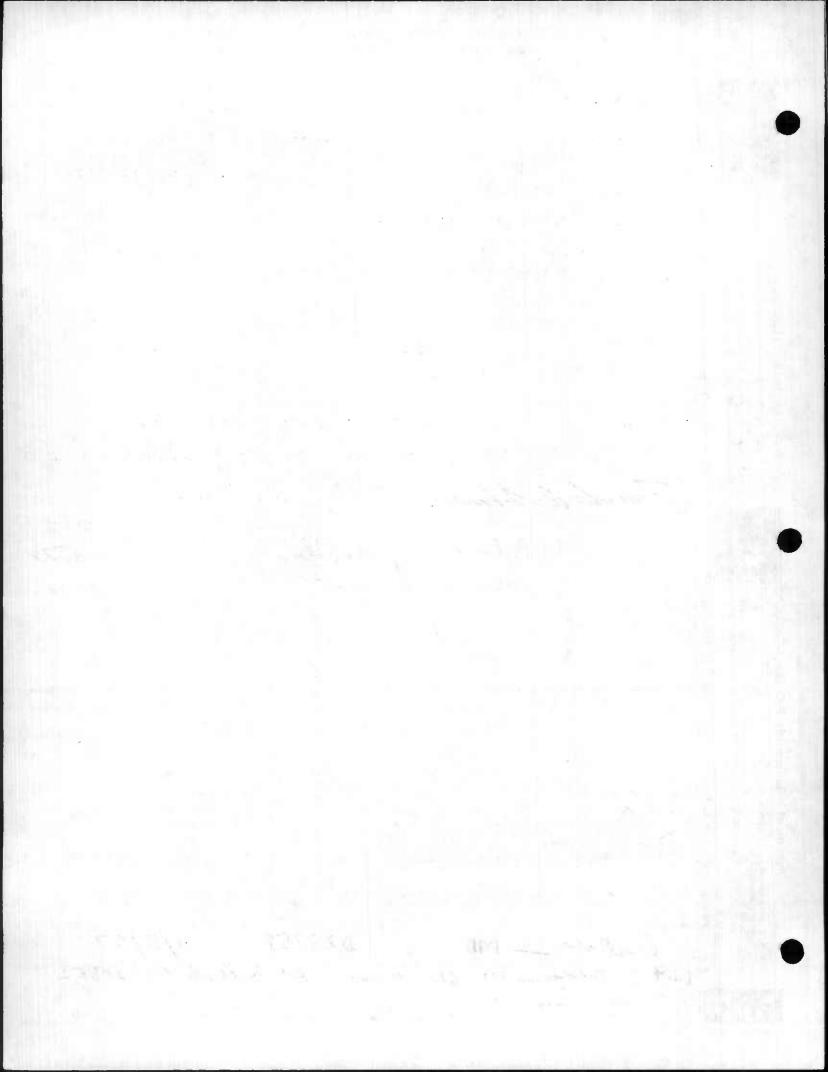
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only SQb. Signature and title p 29c. License number 29d. Dete signed (Month, Dev. Year) D44571 November 10, 1997 30. Neme enduddin of person who completed cause of deeth (hem 23e) (Type, Print) Cockrell, M.D. 7600 Carroll Avenue, Takoma Park, Maryland 20912 James 31. Dete filed (Month NO 32. Registrer's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 7 35656

					Cei	tificate	of L	Death		Reg. N) lo.	J	3030
Physician		1. Decedent's Nama (First, Middla,							2. Data of D	eath	av	Yaar	3. Time of Death
/Medical		ANITA RUTH DUBIN							NOVEMBI		, 199		3:20 PM
Examiner	r	4a. Facility Name (If not institution,		111			4	b. City, Town, or L	ocation of Dea	ith 4	c. County	ot Death	
	_	HEBREW HOME OF G	REATER W	ASHINGT	ON			OCKVILLE		M	ONTG	OMERY	
uneral irector		5. Social Sacurity Number 578-05-8478 Usual Residence of Decadent	5. Sax 1 ☐ M 2K ☐ F	7. Aga (In yrs. 79	. last birthday) Yrs.	It Under 1 Months	Year Days	If Undar 24 Hrs. Hours Min.	8. Date of B (Month, D AUG. 2	irth Day, Yaa	918	9. Birthpl Count NEW	lace (State or Foreign try) YORK
Mo to	- H	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10	0d. Insida City Limits
	5 ,	MARYLAND MONTGOM	EDV		KVILLE							"	1 ☐ Yas 2 ₺ No
or 28a-f sh be notified Director	6	10e. Street and Number	EKI	RUC	KVILLE	101. Zip C	Code			10n C	itizen of \	What Count	tn/2
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r tems 23a direct must. Funeral	5	11. Marital Stalus	12. Was Dece	edant Ever in U	I,S. 13. V			spanic Origin? (Sp n, Mexicen, Puarto	ecify Yes or N			e - Amarice	
by by	2	1 ☐ Never Marriad 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 Tes It Yes, Giv Year or D	2 11 No		Yes, specif			Rican, etc.)			ck, White, a	
rt, the Medical Ex	201	15. Decedent's (Specify only highest			16a. Deced	lent's Usual	Occupa	ation luring most of work)	ha	16b.	Kind of B	usiness/Ind	ustry
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Comp	5	12			SECRE	TARY				NUR	SING	HOME	
or other traumatic event, trail		17. Fathar's Nama (First, Middla, L MAX ZIMRING	ast)	8				18. Mother's Nam		e, Maide	n Su <i>man</i>	ne)	
m l		19a. Intormant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street a	ind Number or Rur	al Route Num	ber, City	or Town,	Stata, Zip	Coda)
		ROBERT DUBIN/SON			10165	GOOD	IN C	CIRCLE, C	OLUMBI.	A, M	ARYL	AND	21046
any Injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3	₩Domessel from		Place of Disportant	sition (Name	of er place	9)	Date	20c. l	Locetion -	City or Tov	wn, State
, La		4 Donation 5 Other (Spe		KIN	NG DAVI	D MEMO	ORIA	L GDNS.1	1/9/97	FAL	LS C	HURCH	, VIRGINIA
any Inju		21. Signature of Funeral Service Li	cansee		22	Name and	Addras	s of Facility	VENCORT	47 0	****		110
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as the bunal-trensit as the bunal-trensit and trensit		disease or condition resulting in death) Sequentially list conditions, if any, leading to Immadiata ceuse. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last	a. VGS		or as a consequence as a consequence or a con	uence ot):	nt	in s				- Ima	reducto
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eteched for usa	Ī	Part II. Other significant condition	contributing to de	ath but not ras	ulting in the un	darlying cau	ıse give	n in Part I.	23b. Did	tobacc	o use co	ntribute to	the cause of death?
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ed in by the funeral Certification:		27. Manner of Death ↑ SNatural 5 ☐ Pending 2 ☐ Accident Investiga	28a. Date of (Monti	of Injury h, Day Year)	28b. Time of Injury	28c	injury Work 1 ☐ Y		28d. Describe				
d in by the		3 ☐ Sulcide 6 ☐ Could no 4 ☐ Homlcide determine	286. Place	of Injury - At ho ag, etc. (Specifi	ome, farm, stre	et, factory, c	office		28t. Location (City or To	(Street a	nd Numb (e)	er or Rural	Route Number,
complately filled in Medical Cert		29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the la aminer: On the ba and mann	sis of examinal	wledge, death tion and/or inv	occurred at estigation, in	the time	e, data and place, inion, daath occurr	and due to the ed at the time,	cause(s	s) and ma id place, a	nner as sta and due to t	ited. tha cause(s)
w comp		29b. Signature and titla of certifiar				29c. L	icansa	number		29d. Da	ate signed	d (Month, D	ay, Year)
		& more		ar		1)2	3958		11	15	197	7
	3	0. Name and address of person when I for the last of t	o complated ceuse		105 M	Print)	se	3958 Pd., F	Rock	ille	MD	20	852
State	3	81. Date tiled (Month, Day, Year)	997 32. Re	agistrar's Signa	ture								
Registrar		MOATA	751 7	Ma David	son-Hand	ملاك							

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Howell 5:05 PM NOV. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Potomac Valley Nursing Home Rockville Montgomery | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month), Dey, Year) | Dec. 20, 1917 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpiece (State or Foreign Country) **Funeral** 12 M 2□ F 214-16-7199 Yrs. Maryland Director 79 Usuel Residence of Decedent the Maryland 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f short must be notified a Montgomery Director Washington Grove 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? be filed within 72 hours after death with P.O. Box 1412 20880 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Detes: items! 11. Marital Stetus 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. event, the Medical Examiner 1 ☐ Never Merried 2 ☐ Married ò by 1 Yes 2 No Specify: Specify: Black 3X Widowed 4 □ Divorced 'natural'. Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) State Road al Hygiene. Elementary/Secondary (0-12) 6th College (1-4or 5+) Laborer Commission Maryland 17. Fether's Neme (First, Middle, Last) 18. Motner's Neme (First, Middle, Maiden Sumame) Be Mental Louise Hawkins Howard Dyson Pages 1 and 2 should other traumatic permit. Pages 1 end 2 shoul Department of Health and Mi Important: If hem 27 is meri any injury or other traumeti 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, M 20615 Shadyside Way, Germantown, MD 20874 Gertrude Dyson (Daughter) 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete ₩Burial 2 Cremetion 3 Removel from State Gaithersburg, MD Brooke Grove Cem. 11/14/97 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funesal Service Licensee 22. Name end Address of Fecility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 Sease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, intro- List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner to (or es e consequence of): rovasculai Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Physiclan/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Aq 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 200No 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Wes cese referred to medicel examiner? 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of De 1 De Neturel 2 Decident 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Aftert To the Hospital or must within 24 hours after death.

To the Funeral Director: After must be fulled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the bests of exemination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) and manner stated. (Check only 290. Signature and till 29c. License number 29d. Dete signed (Month, Dey, Year)

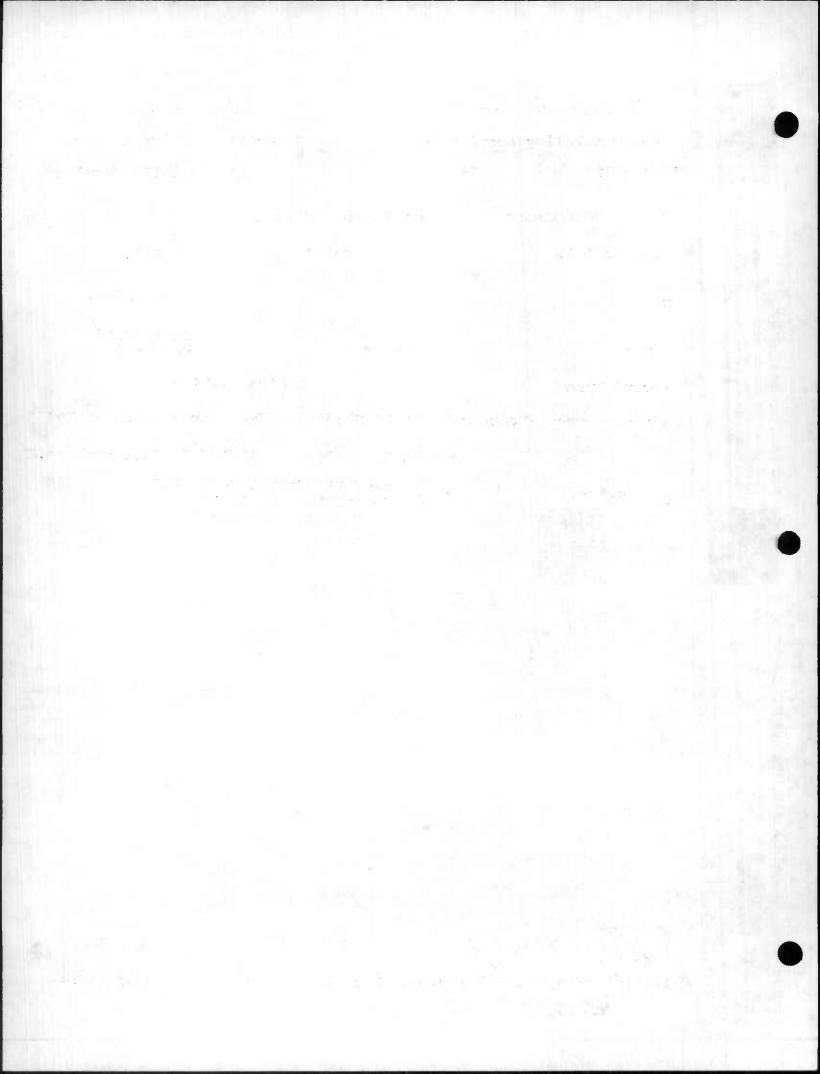
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person who completed cause of deeth (Item 23e) (Type, Print)

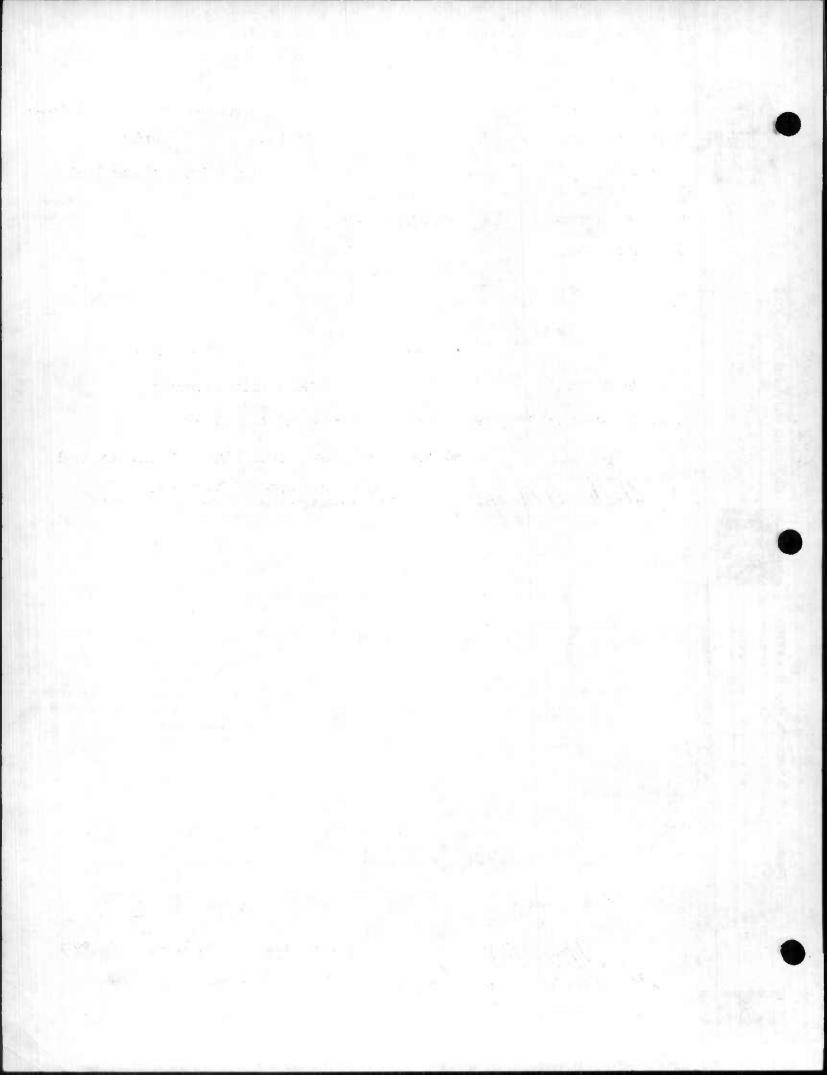
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9707 Medica (Center), #150 Rockville, Wed 20850



State of Maryland / Department of Health and Mental Hygiene 97 35658

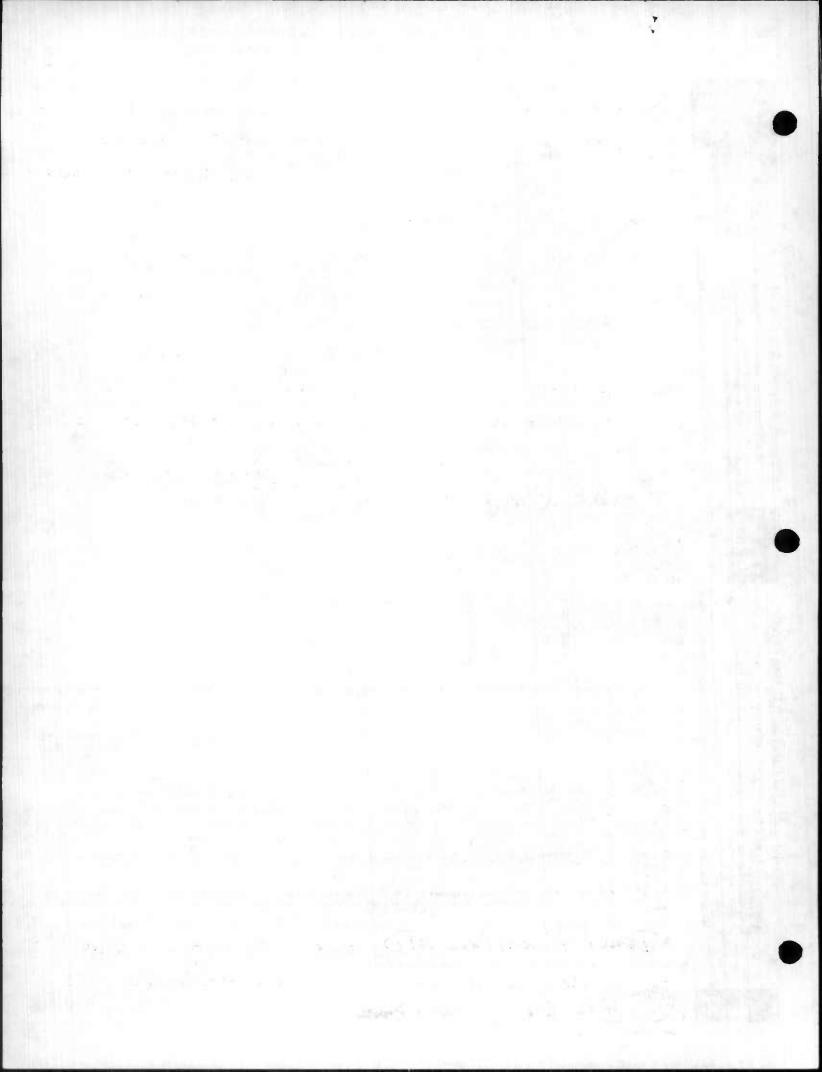
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State of Maryland / Department of Health and Mental Hygiene 97 35659

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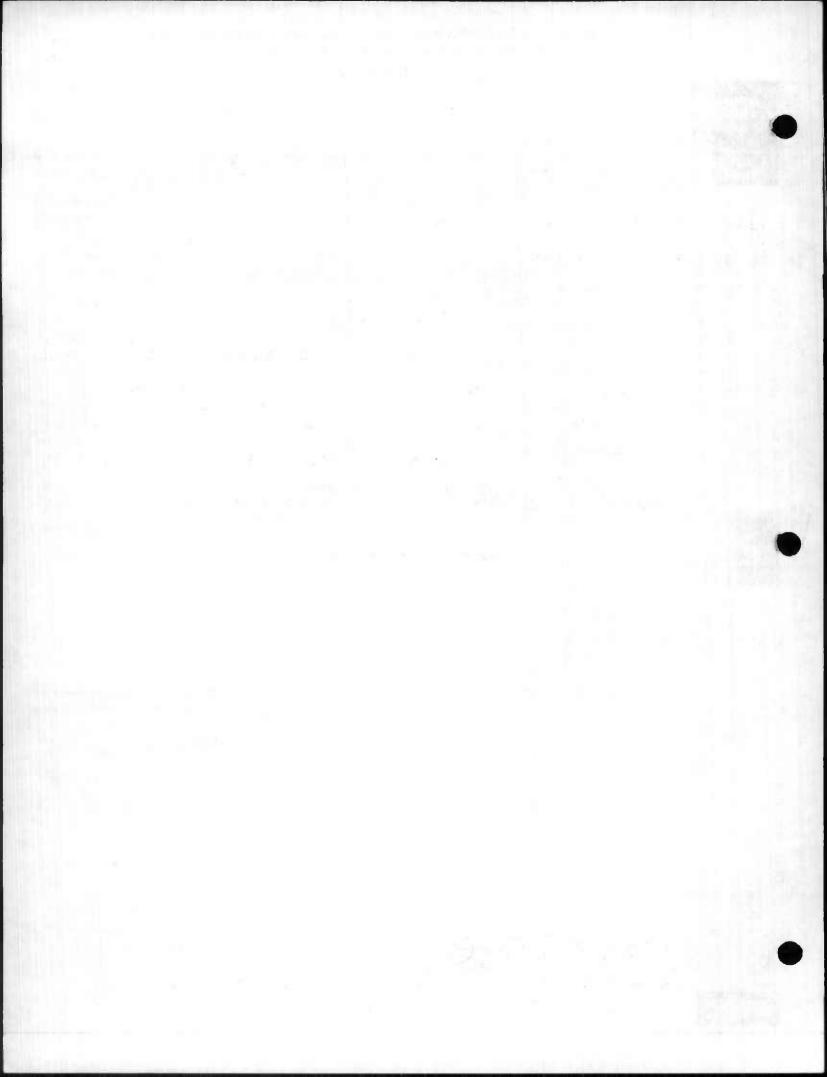
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State of Maryland / Department of Health and Mental Hygiene 9 / 3566 |

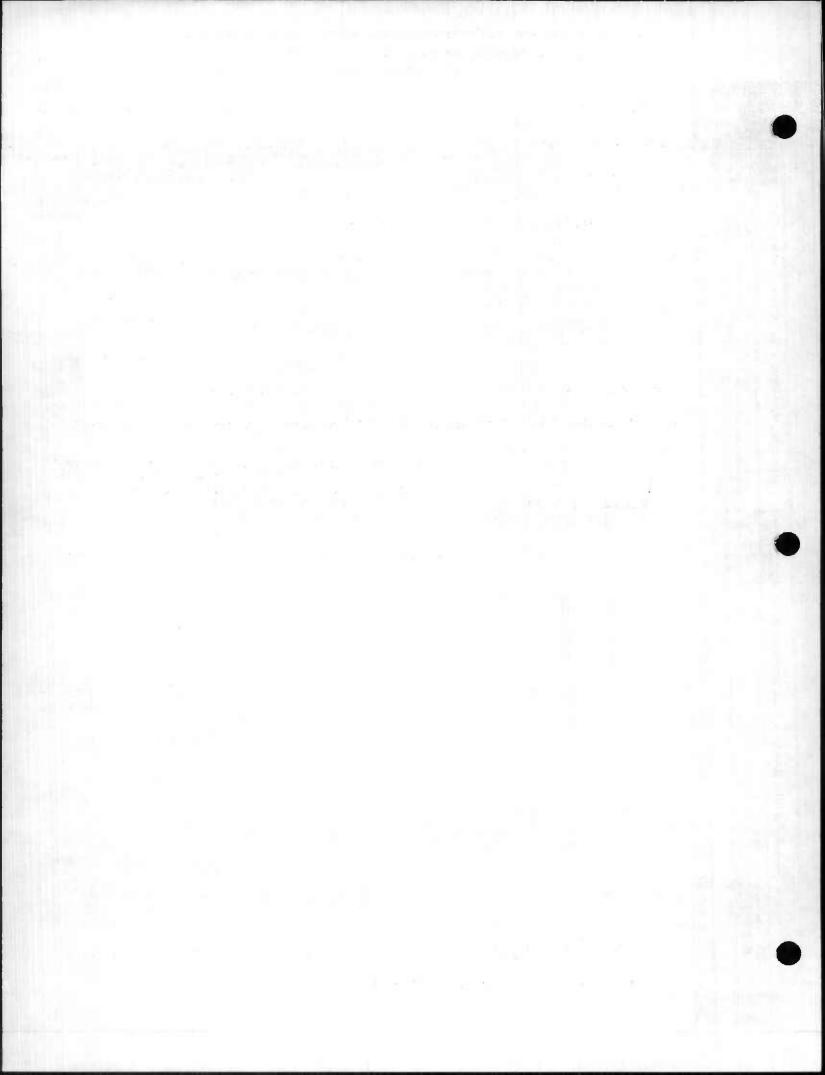
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death **Physician** Month Irva T. Ewell November 9, 1997 9:38 AM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1608 Rainbow Drive Silver Spring Montgomery 5. Sociel Security Number If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1□ M 21 F Days 98 Yrs. Director 225-28-4814 April 1, 1899 Virginia Usuel Residence of Deceden the Marylend 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 ₺ No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? With ò items 23s 1608 Rainbow Drive 20905 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. and an annual or items Peges 1 and 2 should be filed within 72 hours after neat of Health end Mentel Hygiene. It flow 27 is marked other than "natural", or iteaury or other traumatic event, the Medical Experientry or other traumatic event, the Medical Experient. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: White by Specify: 3 ⊠ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Revel Taylor Minnie Wessells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Justice Weese (grandson) 1608 Rainbow Drive, Silver Spring, MD 20905 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 11/11/97 Alexandria, VA Francis J. Collins Funeral 22. Name end Address of Fecility Francis J. Collins F. Home, Inc. 500 University Blvd. West 21. Signature of Funeral Service Licenses Home, Inc. Silver Spring, MD 20901 Surk 23a. Part1. Inter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final Ischemic Cardiomyopathy 2 years disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician end buriel-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the Due to (or es e consequenca of): 98 been signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2₺ No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an eutopsy performed? page 2 s certificete 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 Yes 2 No After this In by the funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 24 hours efter death. Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hosp within 24 hou To the Funer completely fil Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. Attending 29b. Signature and title of Sprtifier 29c. License number 29d. Dete signed (Month, Dey, Year) Physician D18084 November 10, 1997 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) D.D. Patel M.D., 6121 Montrose Road, Rockville, MD 20852 31. Date filed (Month, 32. Registrar's Signature State Julia Savidson-Randoll Registrar

DHMH 16 Rev 6/95



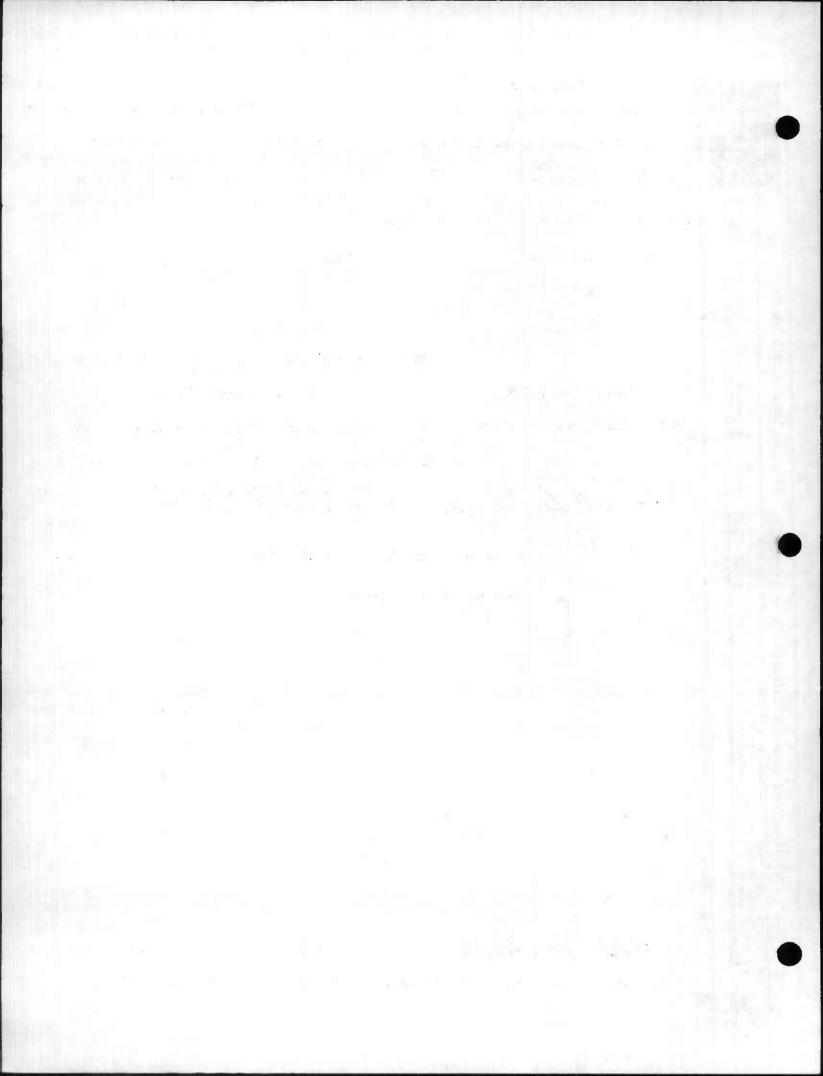
State of Maryland / Department of Health and Mental Hygiene 7

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time f the **Physician** Month 31, Frederick FOX October 1997 11:10 am /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Franklin Square Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1XXM 2□ F Yrs. Director 217-12-0737 75 March 31,1922 Maryland Usual Residence of Decedent with the Merylend 10a Slale 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shot traumatic syant, the Medical Exactions must be notified at Director 1 ☐ Yes 2 X No Maryland Harford Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1208 Perryman Road death Funeral 21001 U.S.A.

14. Race - American Indian,
Black, White, etc. 11. Maritei Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours after a Department of Heelth and Mental Hygiena. Important: if Nem 27 is marked other than "natural;, or them page. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Yeer or Detes: WW II 1 Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Mechanical engineer Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be William Henry Fox Carrie Eleanor Leedom 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Addreas (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Clarissa M. Fox (Spouse) 1208 Perryman Road, Aberdeen, Maryland 21001 20b. Placa of Disposition (Neme of cametery, crematory or other pieca) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Angel Hill Cemetery 11/3/97 Havre de Grace, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Tarring-Cargo Funeral Home, P.A. ennelly Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intervel Betw Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 30 Years Atherosclerotic Cardiovascular Disease Examiner Due to (or as a consequenca of): Examiner Cardiopulmonary Arrest The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last the burial-tran pue Due to (or as a consequence of): Box 68760, attending physician for usa as the buria Physician/Medical Due to (or as a consequence of): USB BSU P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No repital or Attending Physician: The hours after death.

Inerei Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completaly filled edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or Investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) D25363 October 31, 1997 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 9000 Franklin Square Drive Mark Himmelheber M.D. Baltimore, MD 31. Dele filed (Month, Dey, Year) 32 Registrar's Signature State A Budson Ravall MOV 3 1997 Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. 5664 State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month terman 20 Harmer 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Montgomery General Hospital 01ney Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Deys | Hours | Min. | Nov. 21. 5. Sociel Security Number Birthpiaca (State or Foreign Country)
 NJ 7. Age (In yrs. lest birthday) 118 M 2□ F 81 Yrs. 149-01-4290 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Tyes 250 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 N. Leisure World Blvd. 20906 USA 12. Was Decedent Ever in U.S. Armed Forcas? 1 ②Yes 2 □ No If Yes, Give Yaar or Dates: 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) Reca - American Indian, Black, Whita, atc. 1 Nevar Married 2 M Merried 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usuei Occupetion
 (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotiege (1-4or 5+) Mathmatical Statistician Bureau of Census 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Jacob Fastow (Unknown) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Arnette Fasteau-spouse 3330 N. Leisure World Blvd. Silver Spring, MD 20906 ce of Disposition (Neme of Date 20c. Location City or Town, Stata 20b. Plece of Disposition (Neme of cematary, crematory or other pleca) 20e. Method of Disposition 1 Buriel 2 Cramation 3 Removel from Stete 4 Donetlon 5 Other (Specify) Judean Memorial Gardens 11/7/97 Olney, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Edward Sagel Funeral Direction -Daniel Simons 1091 Rockville Pike Rockville, MD 20852

Approximate Intervet Between Onsat and Death Immediete Ceusa (Final diseese or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In deeth) Lest Due to (or es a consequença of): Due to (or as a consequenca of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2000 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy 1 Tyes 2 No 26. Pieca of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpetient 3 DOA

Physician /Medical Examiner

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P.O. Box 68760.

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Division of Vital or Attending Physician: **Physician**

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Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ

4 - Homicide

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28d. Dascribe how injury occurred 28c. Injury et Work?

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

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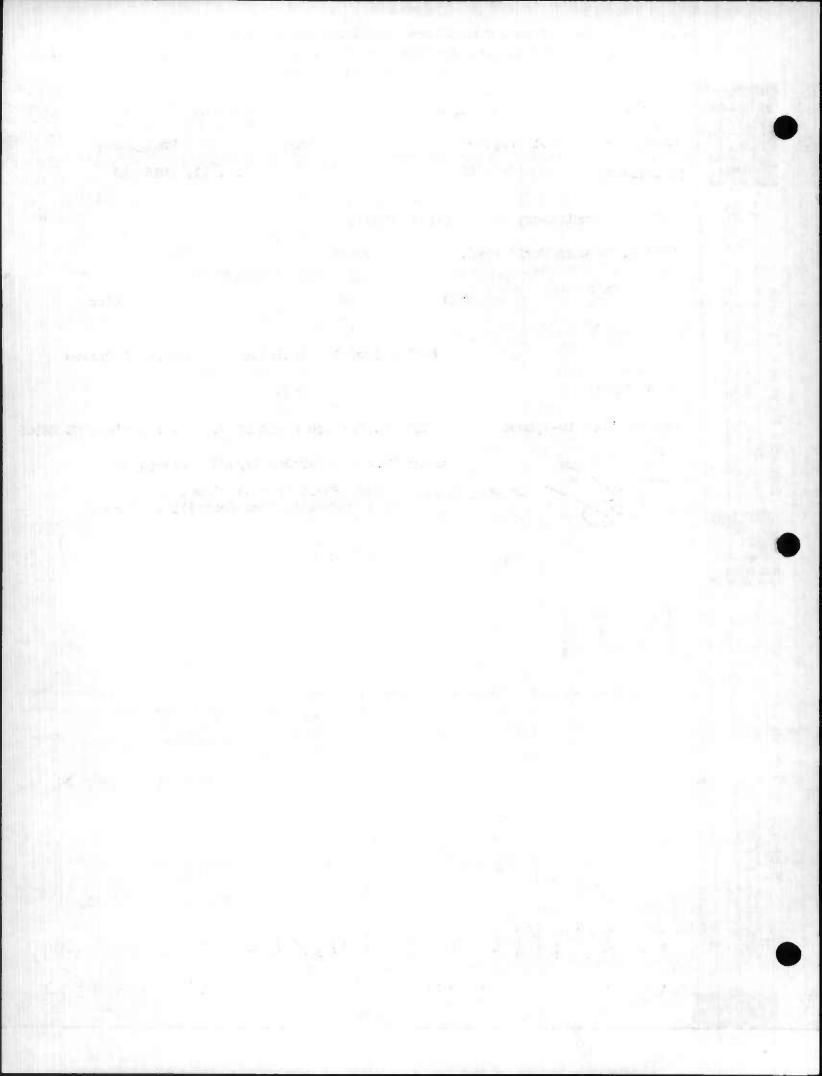
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steled. 29a, Certifier 29b. Signature and title/of 29c. License number

29d. Dete signed (Month, Dey, Year)

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82. Registrar's Signature 31. Deta filed (Month wha Davidson

State Registrar



State of Maryland / Department of Health and Mental Hyoiene 9.7 3.5.6.5.5

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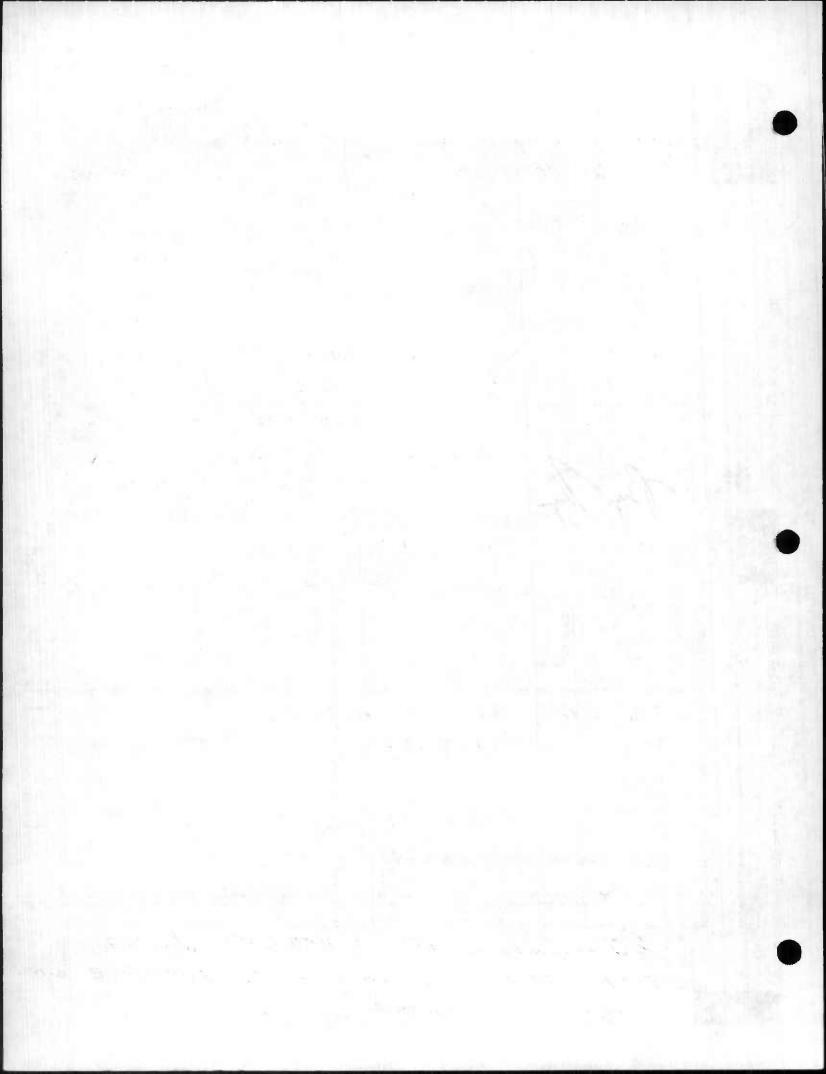
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First Middle Last) 2. Date of Death 3. Time of Deeth **Physician** Month Jack November 13,1997 2:30 PM /Medical 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 7. Age (In yrs. lest birthday) If Under 1 Year if Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** ¥XXM 2□ F Vrs 577-09-7366 95 Director Dec. 11,1901 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 6121 Montrose Rd. 20852 United States 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural'. or itemany injury or other traumetr. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 25tNo If Yes, Give Yeer or Dates: Specify: White þ 3⊖Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Unknown Sales / Management Insurance 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Harris Fox Esther Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 229 Morganza South, Laurel, Maryland Eugene S. Fox 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gdns 11-17-97 Falls Church, Virginia of Funeral Septoe Licenses 22. Name and Address of Fecility
Danzansky-Goldberg Mem. Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, List only one cause on each line. **Physiclan** Immediate Cause (Finel /Medical PNEUMONITIS disease or condition rasulting in death) Examiner Due to (or as a consaquenca of): CEREBROVASCULAR buriel-transit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical the Due to (or as a consequence of): P.O. F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by d CORONARY ARTERY DISEASE 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed SPINAL STENOSIC certificate 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this cardifice completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Placa of Daath (Check only one) Hospitai: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28h Time of Medical Certification: 28d. Describe how injury occurred 28c. Injury at Work? Atten...
efter deeth. 1 Natural 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Couid not be datermined 3 Sulcide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a, Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05885 MID gaan 3 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 6121 NONTROSE RD, ROCKVILLE LIPSON 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death **Physician** Month Helen Fiorentino November 1997 9:35 PM /Medicai 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10837 Whiterim Drive Montgomery Potomac 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 8. Data of Birth 9. Birthpiaca (Ste Country)
June 30, 1948 Mary Land 9. Birthpiaca (Stata or Foraign **Funerai** 1 M 2 F Days 219-48-4010 49 Yrs. Director Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28s-f show must be notified at Maryland Montgomery 1 TYas 2 N No Potomac Director 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò 10837 Whiterim Drive 20854 Items 23s USA permit. Pages 1 and 2 should be filed within 72 hours after deal Ospartment of Health and Mental Hygieno. Important: If item 27 is marked other than "save priciary or other traument. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas ŽŽANo If Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 🗓 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Elementery/Secondary (0-12) Coltega (1-4or 5+) 4 Graphic Designer Advertising 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be William Henry Soper Mary С. Kraft To 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Carl Fiorentino (Husband) 10837 Whiterim Drive, Potomac, Maryland 20854 20b. Placa of Disposition (Name of camatery, crematory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata Metropolitan Crematory 11/9/97 Alexandria, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvica Licansas 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, 500 University Boulevard, West, Silver Spring, Maryland 20901 23a. Part1. Int if the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, an eart feiture. List only one cause on each line. Approximete triterval Batween Onsat and Death **Physician** /Medical Immediata Cause (Final Squamous Cell Carcinoma 10 years disaasa or condition rasuiting in daath) Examiner Due to (or as a consequence of). Physician/Medical Examiner attending physician end for use as the bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseese or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): Box 68760. Dua to (or as a consequence of) P.O. F signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 200 No 3 Probably 4 Unknown Records, þ Completed 24b. Wara autopsy findings availabta prior to 24a. Was an autopsy performed? completion of cause of death? pege 2 s has 1 Yas 2 No After this certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, p. Be 25. Was casa refarrad to madical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2NNo Certification: To 28a. Data of Injury (Month, Dey Year) 27. Mannar of Deeth 28b. Tima of 28d. Dascribe how Injury occurred 28c. tnjury at Work? 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, daath occurred at tha tima, deta and placa, and dua to the cause(s) end manner as steled.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end manner steled. 29a. Certifian Medical 29b. Signatura and title of certifian 29c. Licansa number 29d. Data signed (Month, Dey, Year) D22981 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

2440 M St., NW

1997 32. Registrant Statutur

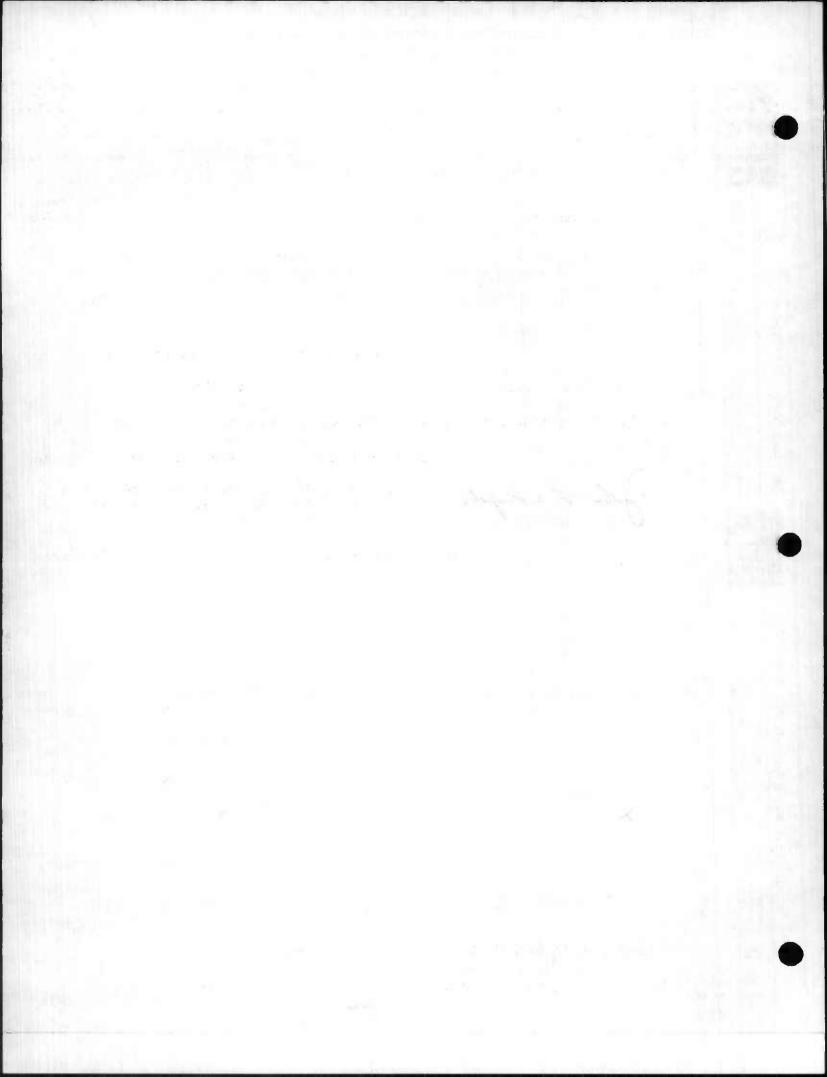
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Washington, DC

State Registrar

Gary H. Miller, MD

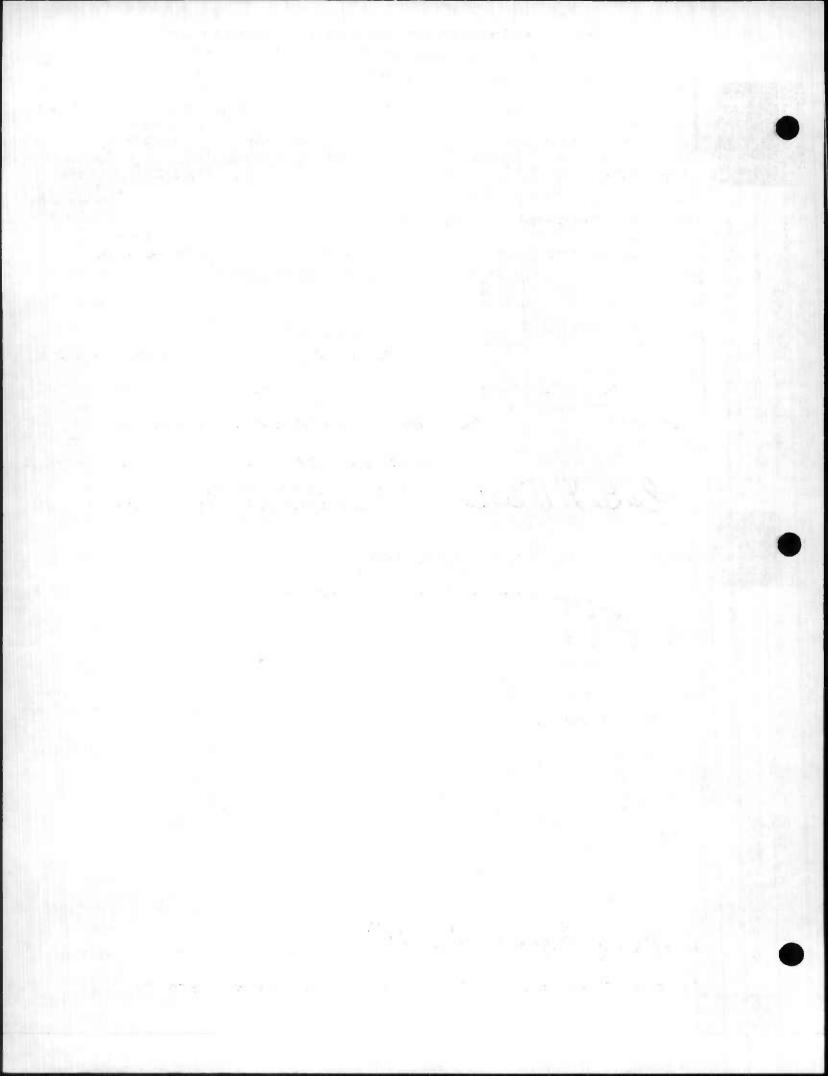
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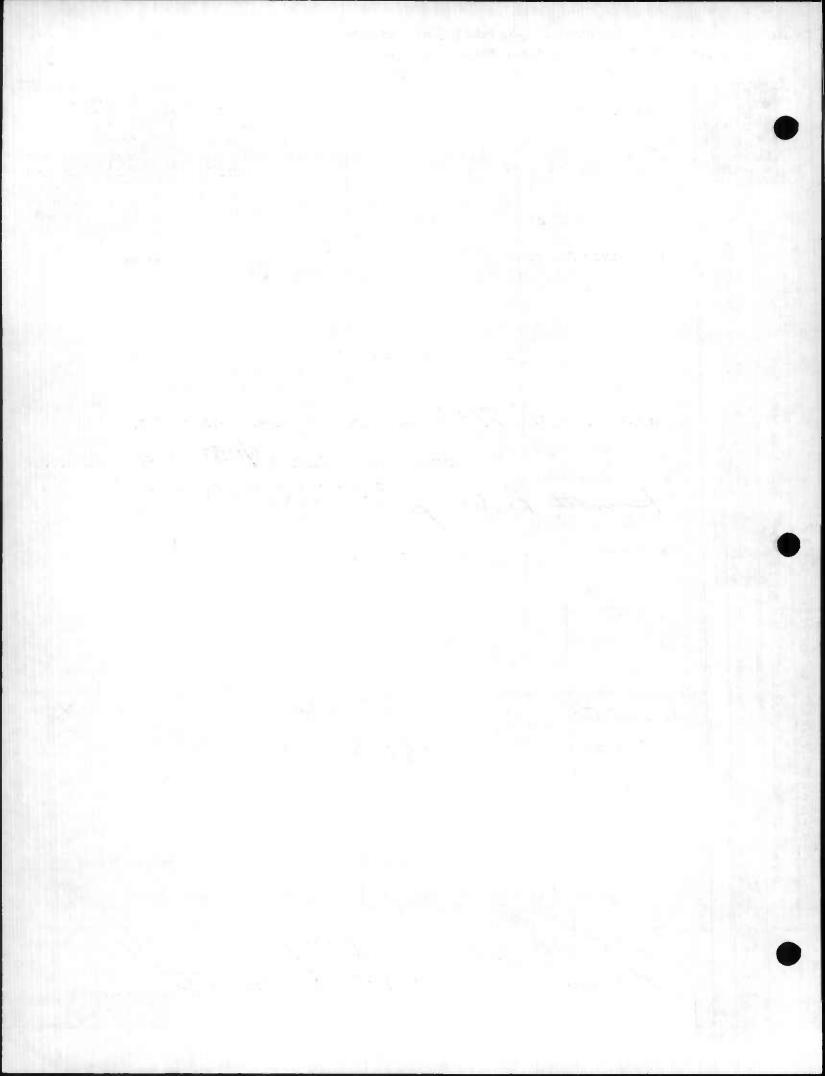
35669 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** Month November 6, 1997 0757 Lala W. Gatling /Medical 4e. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Pay, Year) 9. Birthplace (Stata or Foreign Caughty) North Carolina If Under 1 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** 1 M 200 Yrs. Director 217-60-2413 67 Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 28a-f show Director 1 ☐ Yes 200 No Harford Aberdeen 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ó 1421 Perrywood Drive Herne 23a 21001 U.S.A. Funeral 12. Wes Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yeer or Datas: 11. Marital Stetus Was Decadant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. filed within 72 hours after of Hygiena. other than "natural", or fter 1 ☐ Naver Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilega (1-4or 5+) Homemaker In home 17. Fathar's Name (First, Middla, Last) permit. Pages 1 and 2 should be file Department of Haalth and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Linwood White Jessie R. Askew 19a. informant's Name/Ralationship (Type, Print) Mr. Willie H. Gatling, Sr. (Spouse) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1421 Perrywood Drive, Aberdeen, Maryland 21001 20b. Placa of Disposition (Nama of cematary, crematory or othar place) 20a. Mathod of Disposition Pata 20c. Location - City or Town, State 1 Burlai 2 ☐ Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Harrellsville Baptist Cem Harrellsville, N.C. 21. Signatura of Funguil Servica Licensaa Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that ceused the death of not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Batw **Physician** /Medical Immediata Ceuse (Finel diseasa or condition resulting in daath) Examiner Due to (or as a consequence of): Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consaquance of): girtfona contributing to daath but not rasulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Records, Be Completed by -61K 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 1 No Division of Vital Attending Physician: 25. Was casa referred to medicel axeminar? 26. Placa of Death (Check only ona) Othar: 4☐ Nursing Homa 5☐ Rasidence 6 ☐ Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3□ DOA this filled in by the funaral 27. Manper of Daath 1 Natural 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred Affer 5 Panding invastigation death. 1 ☐ Yas 2 ☐ No 2 Accidant To the Hospital or Attend within 24 hours after daat To the Funeral Director: 3 Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide Scattifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated.

Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner statad. 29a. Certifia: (Check only one) 29b. Signature and title of cepts 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and addrass of parsor 31. Data filed (Month, Day, Yaar) State NOV Registrar

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State of Maryland / Department of Health and Mental Hygiene 9 /

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** 9, MARCOSA FRANCISCO GONZALES NOV. 1997 2:00 PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE

Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)

On the security Number (Month, Dey, Year) MONTGOMERY Birthplece (State or Foreign Country) 1□M 25F Yes 218-29-4872 Director APR. 25, 1916 PHILIPPINES Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Wed cal Examiner must be notified at 1 XYes 2 No Director MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 160 TALBOTT #203 20852 death Funeral PHILIPPINES 12. Wes Decadent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. þ Specify 3 ☐ Widowed 4 ☐ Divorced FILIPINO 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any injury or other traumetic evant, it a Med poles. Elementery/Secondery (0-12) College (1-4or 5+) SALES LADY AGRICULTURE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) MARTIN FRANCISCO SEGUNDA MENDOZA 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) VIRGINIA G. RAYMUNDO/DAUGHTER SAME AS ITEM 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 11/18/97 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) MARILAO MEMORIAL GARDENS INC. MARILAO, PHILIPPINES 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility 20910 MOO091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final unmedials disease or condition resulting in deeth) Examiner Examiner burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated average) Due to (or es e consequence of): physician the burial Physician/Medical thet initieted events resulting in death) Lest Due to (or es e consequenca of): 980 signed by the a d be detached f Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Vunknown p 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peeu 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Wes case referred to-medical Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menney of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation after death Director: / 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piaca, end due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) november 10, 1997 D24971 FRIEDMAN, MD. DENNIS 30. Name and edgress of person who completed cause of deeth (Item 23e) (Type, Print) 31. Dete filed (Month, Dey, Year) 32 Figurar's Signeture Lie Buildson Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** November 8, 1997 Arthur Eric Gropp 10:30P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 6H Crescent Road Greenbelt Prince George's | Under 1 Year | Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | Nov. 10, 1902 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2 F Yrs. 577-58-8414 94 Director Kansas Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinat roust be notified at Prince George's Maryland Greenbelt HEYes 2 No Director 10f. Zip Code 20770 10e. Street and Number 10g. Citizen of What Country? 6H Crescent Road United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes ※XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes No Specify. White Specify: by 3 Widowed 4 □ Divorcad Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health end Mental Hygiena. Important: If them 27 is marked other than "ra any injury or other traumatic event, the Med once. College (1-4or 5+) 3 +2 Elementary/Secondery (0-12) Librarian O.A.S. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Samuel Gropp Henrietta Pritzkatt 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Anne Meglis (Daughter) 2E Westway Greenbelt, Maryland 20770 20b. Placa of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1XX Buriai 2 Cremation 3 Removal from State 11/20/1997 4 ☐ Donation 5 ☐ Other (Specify) Deerfield Cemetery Deerfield, Kansas 21. Signature of Funeral 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause of each line. Approximete Intervel Betw **Physician** Heart Disease /Medical immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequenca of): physicien a Box 68760. Physician/Medical the Due to (or as a consequenca of): attanding i P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Dehydration 1 Yes 2 No 3 Probably 4 Unknown been signed to should be date Records, by 24a. Was en eutopsy parformed? 24b. Were autopsy findings available prior to completion of cause of death? Be Completed paga 2 1□ Yes 2 No 1 ☐ Yes 2 No cartificeta Division of Vital Hospital or Attending Physician: director, 25. Was cese referred to medical 28. Place of Deeth (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To this funaral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Aftar 5 Pending investigation s efter death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, offica building, etc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Directomplately filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

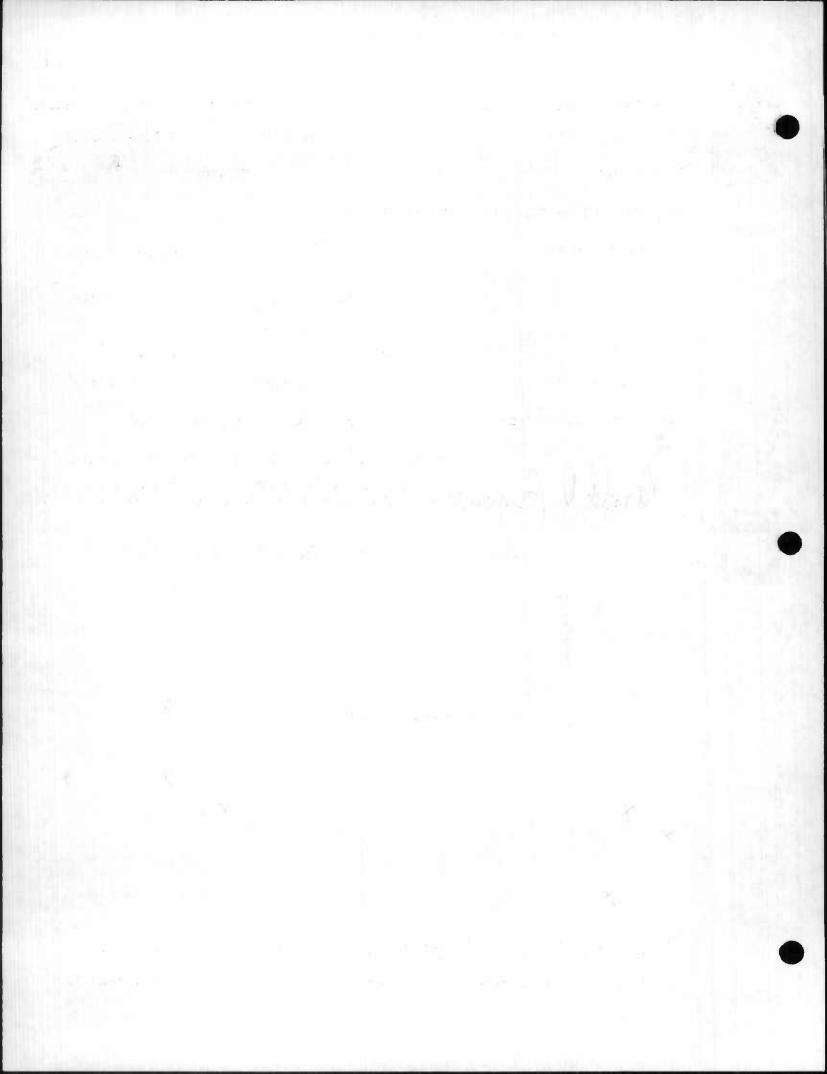
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 10,1997 30. Name end address of person who completed cause of deeth (Item 23a) (Typa, Print)

State Registrar

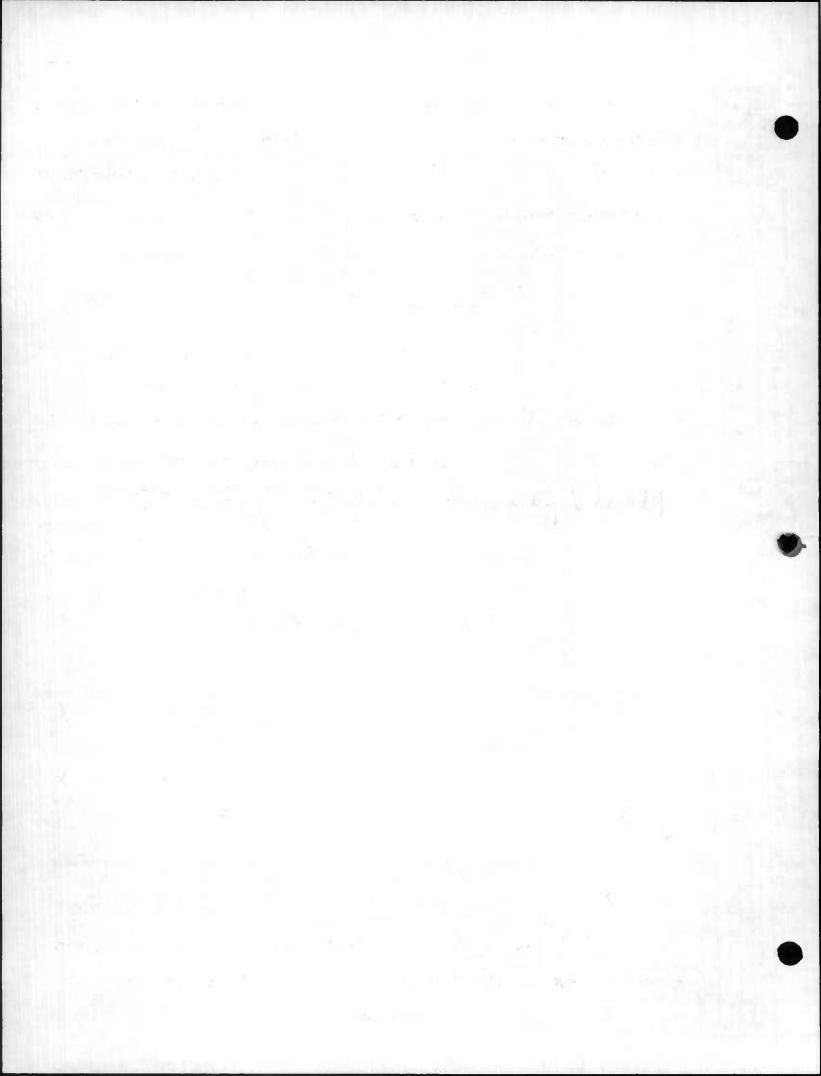
31. Date filed (Month, Day, Year) NOV 12 1997

32. Registrer's Signature

David S. Schachter, M.D. 7525 Greenway Ctr. Dr. #212 Greenbelt, Maryland 20770



					Certifica	ite of	Death		Re	eg. No.		
Physici	20	1. Decedent's Name (First, Middle, L		entilin					2. Date of Deat	Davi	Year	3. Time of Death
Physick /Medic		Joseph J				Novemb	per'6,	1997	11:55A.			
Examin	er	4e. Fecility Neme (If not institution, g 3507 Susquehanna				wn, or Lo 705	ocation of Deeth		4c. County of Death United States			
unerai irector		171-01-0417	Sex 7. A	Age (In yrs. last birt	Yrs. If Unc Month	er 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Dec • 27	Year)	Coun	lace (State or Foreig try) ISYLVania
Health and Mental Hygiene. fem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's	10c. City, Town	or Location						10	0d. Inside City Limit
	i Director	10e. Street and Number 3507 Susquehann		ip Code 20705			11	Og. Citizen of				
	by Funeral	11. Marital Stetus 1 Never Married 2 Married 3XXVidowed 4 Divorced	If Ves Give	?	1∏ Ves		dispanic Orlean, Mexican Specify:	gin? (Spi , Puerto	ecity Yes or No- Rican, etc.)		ca - Americack, White, of	
	Completed	15. Decedent's (Specify only highest g	Education grade completed)	16e.	Decedent's Us (Give kind of the life. DO NOT	vork done	during most	of work	ing	16b. Kind of E	Business/Inc	lustry
	Be Com	Elementary/Secondary (0-12) 12 12 17. Fether's Neme (First, Middle, Las	College (1-4or	2 L	CDR		18. Mothe	r's Name	(First, Middle, N	Navy-I		ed
	ToB	Louis			eph i		Dono					
		19a. Informant's Name/Relationship Mary Louise Gent	(Type, Print) tilini (Da	ughter)	Mailing Address 3507 St	ss (Street usque	and Numbe hanna	Dr.	Beltsv	City or Town	n, State, Zip Maryla	code) and 20705
iding physicia isa es the bur	Med	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Congr. b. Mer. c. Met.	Due to (or as a co	consequence	4	ilen O	C	on con			Approximate Interval Between Onset and Death Welch
signed by the ettan I be detached for u	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4		
2 should	Completed by								24a. Was a	n autopsy ned?	cor	ore autopsy findings ilable prior to npletion of cause death?
icate has									1 □ Y€	s 2 KNo	10	Yes 2000
After this cartific funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 VNo 27. Manner of Death 1 SAlatural 5 Pending investigatis 3 Sulcide 6 Could not	be 28e. Place of In		Time of njury M	28c. Injur Wor 1	ler: 4□ Nu	rsing Ho	me 5 Reside 28d. Describe ho 28f. Location (St. City or Town	once 6 Ottown injury occur	rred	')
Director in by th	THE STATE OF	3 ☐ Sulcide 6 ☐ Could not: 4 ☐ Homicide determine	building, 6							, olato)		Route Number,
Funeral Director stely filled in by th		4 Homicide determined	Physician: To the best aminer: On the basis of	t of my knowledge, of examination and	, death occurre	d at the tin	ne, date and	d place, a	and due to the ca ed at the time, da	use(s) and m	nanner as st	ated.
To the Funeral Director: A completely filled in by that	Medical	4 Homicide determined	Physician: To the best aminer: On the basis of end menner st	t of my knowledge, of examination and stated.	d/or investigation	en, in my o	pinion, deal	h occurr	ed at the time, da	ause(s) and mate and place,	, and due to ed (Month, I	ated. the cause(s)



State of Maryland / Department of Health and Mental Hygiene 0.7

						Cer	tificate of	Death	R	eg. No.	1 0	0013		
	Physic /Medi		1. Decedent's Name (First, Middle, I James Albert	2. Date of Dea Month NOVEMB	th Day	Yeer	Time of Death							
	Exami	As Facility Manual (Manual Institution of a set a facility of a facility												
1			PHYSICIANS MEMOR	IAL HOSPIT	'AL			LA PLATA		CHARI	ES COUN	TY		
Т	Funeral	Г	Social Security Number 6.		ge (in yrs. last	birthdey)	If Under 1 Year Months Days		8. Date of Birth (Month, Dey		9. Birthplace	(Stete or Foreign		
Director			216-70-8990	1 M 2□ F	41	Yrs.	Month Days	Tiours iviii,		14, 19	Country)	0		
	pu »		Usual Residence of Decedent		10- 0h T					,				
	5-0020 72 hours effer death with the Maryland natural; or Itams 23a or 28a-f show diest Examiner must be notified at	ctor	MD 10b. County Char	Les	10c. City, T	aldo						nside City Limits		
		al Dire	10e. Street and Number 2745 Stavors I	Rd.			10f. Zip Code 20	603	1		What Country?			
020		by	11. Maritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give			Hispanlc Origin? (Spoan, Mexicen, Puerto	eclfy Yes or No- Rican, etc.)		ce - American Ir ck, White, etc.			
21215-0020	vithin han	Completed	15. Decedent's (Specify only highest of Elamentary/Sepondary (0-12)	Education rade complated) Collega (1-4or	6a. Decede (Give k lifa. D		petion of during most of work ed) ty Contr	ing		usiness/industr				
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yla	should band Ments i marked	To	Russell Thomas	s Hamilto	n			Lucille A. Montgomery Hamilto						
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more,			20a. Method of Disposition 20b. Place of Disposition (Neme of genetary, cremetory or other place) 20c. Location - City or Tow 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of genetary, cremetory or other place) Trinity Mem. Gardens 11/14/97 Waldorf, I											
HE			21. Signature of Funeral Sarvice Lic			22.	Nama and Addr	ess of Facility						
B	Depa Depa Impo		David (100945	P	.O. Bo:	ess of Facility -ECHOLS x 567 La	Plata,	MD 206				
ı	Physician /Medical		23a. Par11. Enter tha diseese, or co shock, or heart feilure. List onl Immediata Cause (Final disease or condition	y ona cause on each l	line.			ing, such as cardiac $\Delta M V \Delta S$			Inta Ons	proximate rval Between set end Deeth		
L	Examiner	Jec	resulting in death)	a. 16	Due to (or as			1016	01201-					
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Box	death death de etten	Physician								23b. Did tobacco use contribute to the cause of death				
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٣,	that the	by P							1 4	es 2⊔No	3 Probably	4 Unknown		
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Vital	ilcian: The certificate rector, peg	Be	25. Was cese refarred to medical examiner?					26. Placa of Deat	h (Check only on	e)				
10	5 00	2	1⊠ Yas 2□ No	Hospitai: 1 ☐ Inpati	ient 2 KER/	Outpatient	3□ DOA O	har: 4 Nursing Ho	me 5 🗆 Reside	ence 6 Oth	er (Specify)			
	After fune	ation:	27. Manne of Death 1 Natural 5 Pending 2 Accident Investigati	28e. Date of Inju (Month, Da	ury ay Year) 281	b. Time of Injury	M 1 [rry et ork?] Yes 2 □ No	28d. Describe ho	ow Injury occur	red			
Division	5 4 5 5	ertification:	3 Sulcide 6 Could not detarmine	d 28e. Place of in	jury - At home tc. (Specify)	farm, stre	et, factory, office		28f. Location (Si City or Town		ber or Rurel Ro	ite Number,		
	To the Hospital within 24 hours e To the Funeral Completely filled	edical C		hyalclan: To the bast iminer: On the basis of end manner st	of examination									
	within 2 To the	Me	29b. Signature end title of certifiar	.14	29c. License number					29d. Date signed (Month, Dey, Yeer)				

State Registrar

NOV 1 4 1997

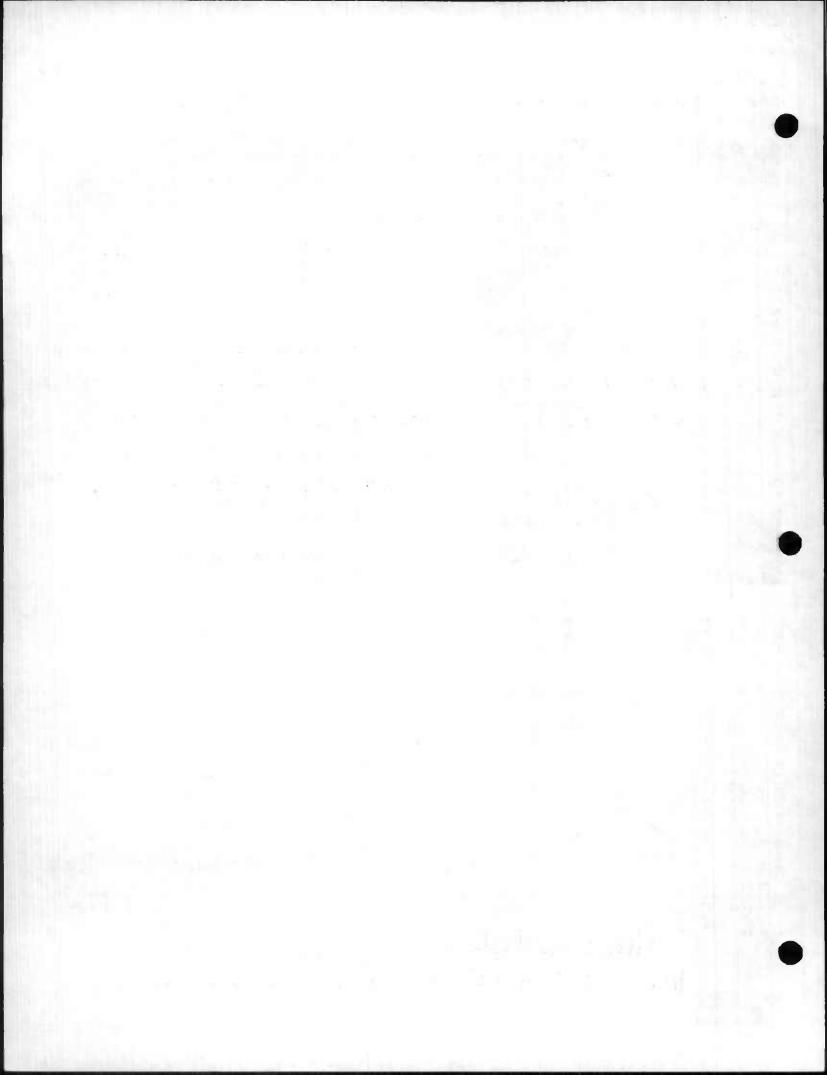
Rysours

LOREU WM. 111 Penn Street, Baltimore, Maryland 21201

o complated causa of death (Item 23a) (Type, Print)

O.C.M.E.

NOVEMBER 12, 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death 1997 Month CLAUDE E. HARKINS 2:400M November 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Union Memorial Hospital BAltimore city 5. Social Security Number 6. Sex 1 ★ 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Dete of Birth (Month, Dey, Year) Hours 218-14-6769 Yrs. 8/2/17 MAryland . Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits Harford MD Street 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? 3419 Thomas Bridge Road 21154 USA 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Rece - American Indian, Bleck, White, atc. 1 Navar Married 2000 Parried Yes 2 □ No If Yes, Give 1 Yas 2 KK Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Yaar or Retos: 2 15. Decedent's Education (Spacify only highest grada completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Constuction Superintendent 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Cameron L. Harkins Blanche Huff 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) E. Alverta Harkins- wife 3419 Thomas Bridge Rd. Street, MD 21154 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Seriel 2 Cremetion 3 Removel from State 11/8/97 4 ☐ Donetion 5 ☐ Other (Specify) Emory Cemetery Street, MD 21. Signature of Funerei Service/Licensee 22. Nema and Addrass of Fecility Harkins F.H.Inc., Delta, PA 17314 23 Fert1. Enter the disease, or complications that causad the deeth. Do not entar the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death Immediete Ceuse (Finel diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseesa or Injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of). Pert II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Stenesis 24b. Were eutopsy findings evellable prior to completion of ceusa of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes cese referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 Pinpatlant

Physician /Medical Examiner

Physician

/Medical

Examiner

10e State

Funeral

Director

28a-f show

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Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Haalth end Mental Hygiena. Important: If Item 27 is marked other than "natural", or flet any Injury or other traumatic event, the Medical Examinations, page.

Baltimore, Maryland 21215-0020

event, the Medical Examiner must be notified at

Director

Funeral

by

Completed

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Examiner Physician/Medical by Completed Be

burial-transit physician s the burial for use es ate has been signed by the e page 2 should be detached t this certificate funeral director, Medicai Certification: To After after death Director: filled in by the

or Attending Physician: The law requires that the death certificate be axecuted

Division

To the Hospital of within 24 hours at To the Funeral D completaly

death.

Hospital

State Registrar

31. Dete filed (Month, Dey, Year)

1 Yas 2 No

5 Pending Investigation

6 Could not ba determined

27. Menner of Deeth

2 Accident

3 Suicide

29e. Certifier

4 Homicide

29b. Signature end title of certifier

1 Neturel

who completed ceuse of deeth (Item 33) (Type, Print)

2 ER/Outpatient 3 DOA

28b. Time of injury

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number

28c. Injury et Work?

1 Tyes 2 No

1 Certifying Physicten: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and piece, end due to the ceuse(s) end mannar steted. 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

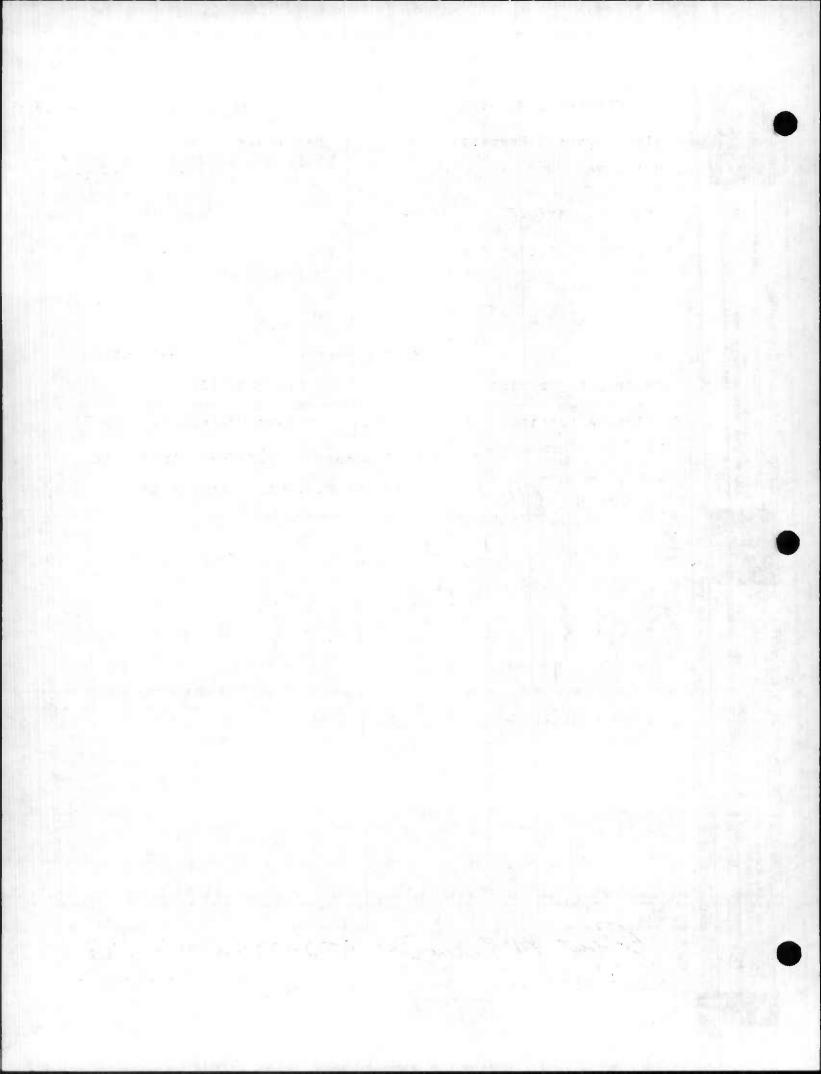
28d. Describe how Injury occurred

lemoria 1

32. Registrar's Signeture a Studier Randall

28a. Dete of Injury (Month, Dey Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physiclan** NOV 12 1997 2:15 P MARGARET ELIZABETH HATTER /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner DE GRACE HARFORD BREVIN NURSING HOME HAVRE 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth 9. Birthplece (State or For (Month, Day, Year) Pennsylvania 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 2Q,F Deys Yrs. Director 77 160-16-0165 Usuei Residenca of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at X□ Yes 2□No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 421 South Union Avenue 21078 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No if Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indien, Bleck, White, etc. 72 hours efter 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White by Specify: 3 ♥Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) 5+ School Teacher Public Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Lloyd Henry Kennedy Ethel A. Ebersole 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1104 Oak Ridge Ct., Bel Air, Maryland 21014 Carol E. Penner - Daughter 20b. Plece of Disposition (Neme of cametery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) All Saints Cemetery 11-14-97 Reisterstown, Maryland 21. Signa ure of Funerel Service License 22. Neme end Address of Fecility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Pert1. Enter the disease, or complications and shock, or heert feilure. List only one could be a complete. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Ceuse (Finel diseese or condition resulting in deeth) RENAL FAILURE 3 MONTHS **Examiner** Due to (or es e consequence of). Examiner BILATERAL HYDRONEPHROSIS 3 MONTHS requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Pue Due to (or es e consequença of): physician en Box 68760 Physician/Medicai Due to (or es e consequence of) for use es 950 P.O. Pert ii. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELITUS Records, þ 99 Completed 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? ate hes t 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) exeminer? Hospitei: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homleide edicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) end menner steted. (Check only 29b. Signeture end title of certifier 29c. License number

Registrar

31. Dete filed (Month, Day, Year) NOV1 4 1997

30. Name end eddress of person who completed cause of deeth (item 23a) (Type, Print)

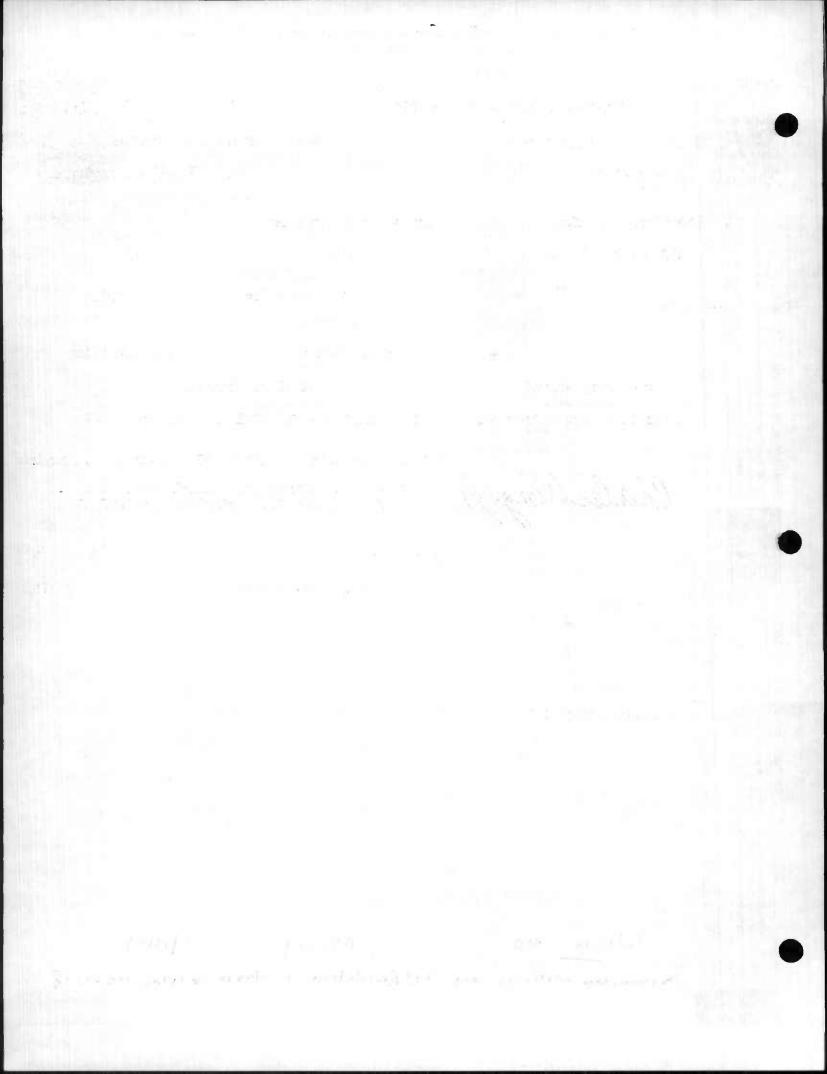
Willian

703 Revolution St Hours De Gran MS 2107 & Kammoun Muhan Ms 32 Registrar's Signeture

D32600

29d. Date signed (Month, Day, Year)

11/13/4)



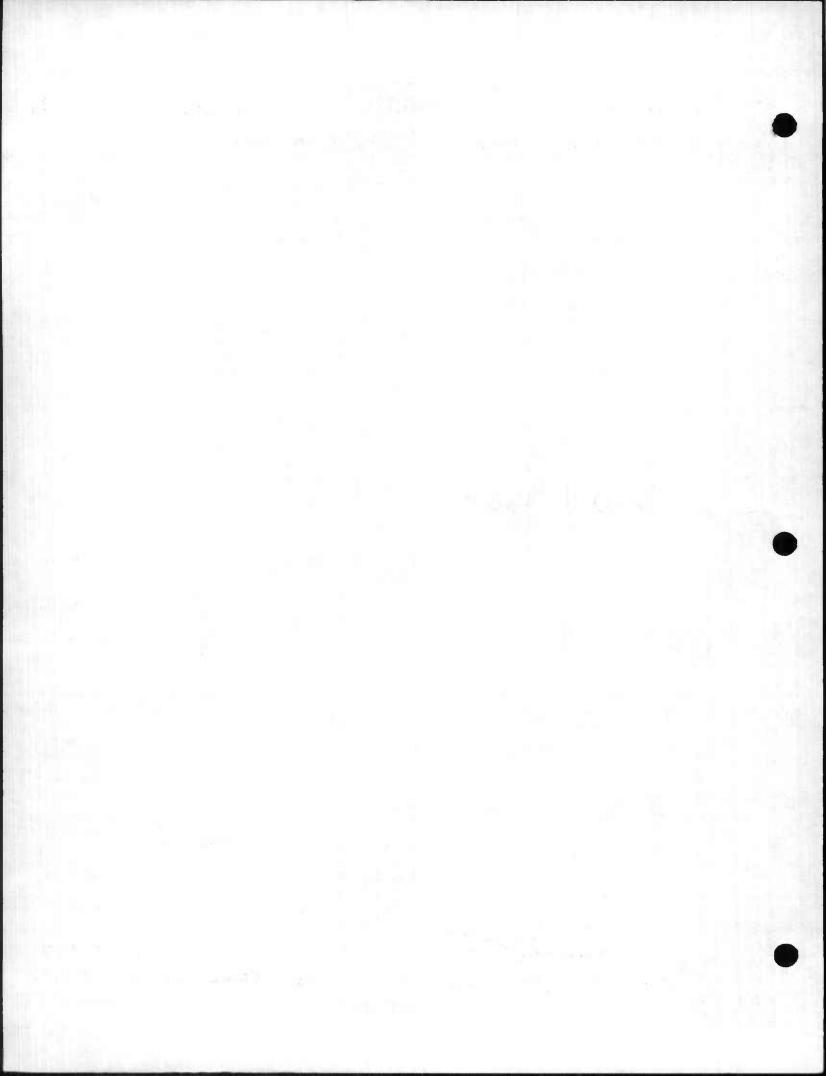
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Yeer Physician HELTON EVELYN 00:24 Virginia November 0 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BAltimore Hopkins Hospital | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth NOV 29, 1954 5. Social Security Number 7. Age (in yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** 1 M 2 X Mary land 205-44-6637 42 Yrs Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 23s-4 show any injury or other traumatic event, the Medical Exercited Function and page. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Laurel 1 Yes 20 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 252 Marganza South United States 12. Wes Decedent Ever In U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritel Status 1 Never Merried XX Merried Baltimore, Maryland 21215-0020 1 Yes 2000 White Specify þ 3 Widowed 4 Divorced Completed 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Sales -- Printing Self Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Hunter Rowe Audrey Deane 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) William R. Helton (Husband) 5808 Hanna Rd. Eldersburg, Maryland 21784 20b. Plece of Disposition (Name of cametery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ② Cremetion 3 ☐ Removel from Stete Metropolitan Crematory 11/10/1997 Alexandria, Virginia 4 □ Panetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensia 22. Neme and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 BANN DIGWOUDS 23a. Pert1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical 8 days RaumAtik Examiner Due to (or as a consequence of): Examiner requires that the death certificate be axecuted attending physician and for use as the burial-transit Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) resulting In death) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown distron by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed cartificata has 1 | Yes 2 10 NO 1 Yes 2 No Attending Physician: 25. Wes case referred to medical examiner? Be 28. Place of Death (Check only one) Hospitel: 1 Nes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: Aftar a moter cycle 1 Neturel 5 Pending Investigation s after death. passanger 1 Ves 2 No 7:00 10/3/97 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 8 STREET Amudel Anne 24 hours a Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Cartifier To the Hosp within 24 ho To the Fune complately f (Check only one) 29b. Signeture end title of confine 29c. License number 29d, Dete signed (Month, Dev. Year) RES-000 November 8, 1997 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Wolfe Street, BAltimore 21287 Wilman North Christine 600 32. Registrar's Signature
Sucha Variation Rendere State Registrar

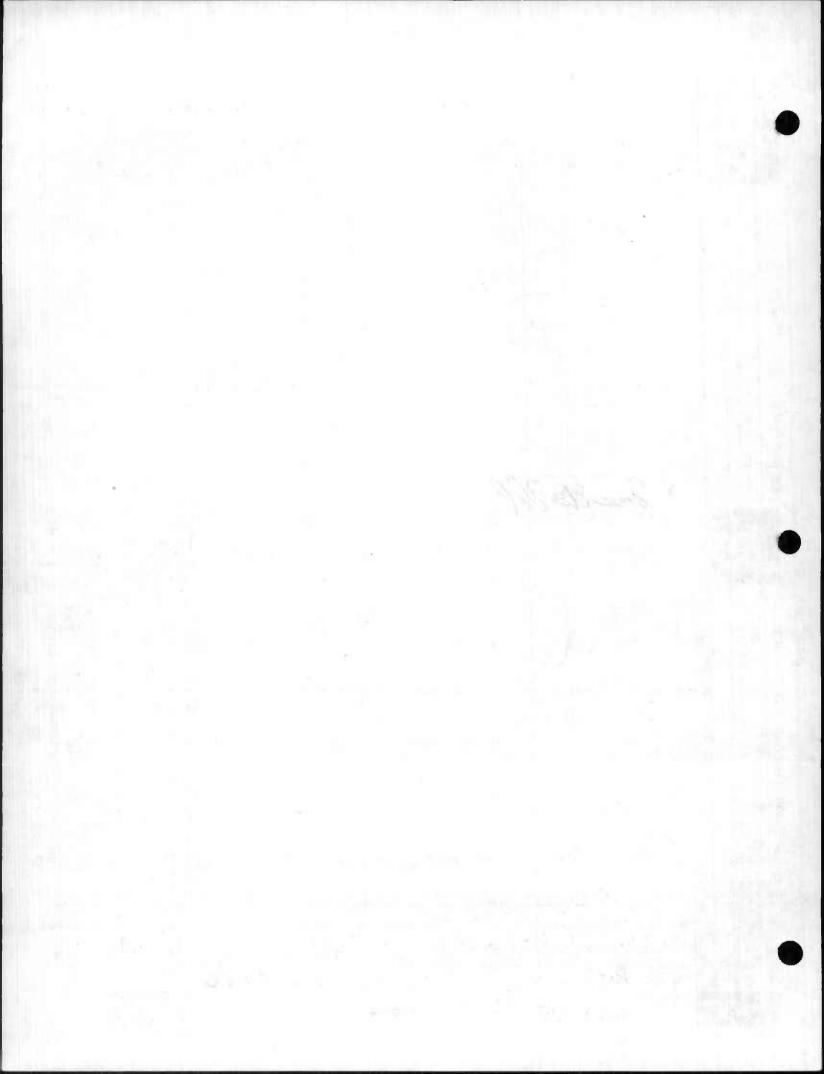
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate	e of	Death		F	Reg. No.	1 3	5677
	1. Decedent's Name (First, Midd	lle, Last)									Venr	3. Time of Death
Massa D 11 77											2:40 PM	
	4e. Fecility Name (If not institution	n, give street end nu	nbar)				4b. City, To	own, or Lo	ocation of Deeth	4c. Count	y of Deeth	
	PLeasant I	iving Nur	sing Cer	nter			Edg	ewate			Arun	del
	5. Sociel Security Number 465–24–0735	6. Sax 1 ☐ M 2 🖾 F	7. Age (In yrs. le 74	st birthdey) Yrs.	If Under Months	1 Year Days	if Under Hours	24 Hrs. Min.	8. Dete of Birt (Month, De) Dec. 1.	Year) 3, 1922	COLH	olece (Stete or Foreign htry)
1	Usuel Residence of Decedent										1	
CIOL												0d. Inside City Limits 1 X Yes 2 No
5	10e. Street and Number									10g. Citizen of	Whet Cour	ntry?
0	144 Washingto	n Rd.			21	.037				U.S	5.A.	
Dy rune		Armed Fo	rces? 21 No e	3					ecify Yes or No- Rican, etc.)		ck, Whita,	
				16e Dece	dent's Heus	Оссия	netion			16h Kind of F	lucinose/In	
100	(Specify only highs	st grede completed)		(Give	kind of worl	k done	during mos	at of worki	ing	100. Killa oi b	usiness/in	oustry
Ē	Elementary/Secondary (0-12)									Public	Rela:	tions
3	17. Father's Nema (First, Middle,			1 .10.	ridital	1.5 0						CIONS
9	Monnie Rowell											
1	19a. Informent'a Name/Relations	ship (Type, Print)		19h Meilir	na Address	(Street					State 7in	Code)
1												
1		/ 5011	20b. Pla	ce of Dispo	sition (Nem	e of		23,	Annapol Date			
	1 ☐ Burial 2 ☑ Cremation		stata	-	-						- 1	
ŀ			Met						.10,9/	Alexand	iria,	Va.
ľ	21. Signature Funerer Sarvica	ICONSEC A	7					,				
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	23a. Party. Enter the diseesa, or heert feilura. List	complications thet can be consulted to the can be consulted to the can be consulted to the can be ca	aused the death. ach line.	Do not ent	er the mode	of dyir	ng, such as	cardiac o	or respiretory er	rest,		Approximate Intervel Between
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	Immediate Cause (Final disease or condition		acdio	hul	mon	a	70	06	rest			2 hcc
	resulting in death)	е.				11	7	U.			1	W III
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	Sequentially list conditions	b		es a consec	uence of):	VUI	Inc					
	Cause (Disease or injury that initiated events									2 yrs		
3	resulting in death) Last										2 mg	
	d.									1	0	
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	3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Numb City or Town, Stete)								ber or Rura	l Route Number,		
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			er stated.		200	Licenc	a number			29d. Dete signe	d (Manth	Nev Yeer
	2565. Signature sort time of opening	Y X 1			250.	-ivalis	a mulliper			Journal Signe	a (MOHIII,	way, rodi)
	29b. Signature and title of certifia	Via	DA. N			11.0	VIA F			111.	10-	
	▶ Wonua	lich	NEMID		<u> </u>	142	3101			11/10	197	
	30. Neme and eddress of person				Print)	42	3101		11	11/10	197	
	Monitor So. Neme and eddress of person	e Hung	of death (Item 2 Secur)	na	Print) POCK)42 E	810 [MD	2	1146	11/10	197	
meaning symmetry of the confidence of the confid		Mary R. 4e. Fecility Name (if not institution Pleasant I Pleasant I S. Social Security Number 465-24-0735 Usuel Residence of Decedent 10a. Stete 10b. County Md. Anne 10e. Street and Number 144 Washington 11. Marital Status 1 Nevar Married 2 Marian 3 Widowed 4 Xipivorced (Specify only higher Elementary/Secondary (0-12) 17. Father's Nema (First, Middle, Monnie Rowell 19a. Informent'a Name/Relations David A. Caney 20e. Method of Disposition 1 Burial 2 Xi Cremation 1 David A. Caney 20e. Method of Disposition 1 David A. Caney 20e. Method of Disposition 1 David A. Caney 20e. Method of Disposition 1 Signature Funeral Sarvica 23a. Party Enter the disease of David A. Caney 20e. Method of Disposition 1 David A. Caney 20e. Method of Disposition 2 David A. Caney 20e. Method of Disposition 3 David A. Caney 20e. Method of Disposition 1 David A. Caney 20e. Method of Disposition 2 David A. Caney 20e. Method of Disposition 3 David A. Caney 20e. Method of David A. Caney 20e. Method of Disposition 3 David A. Caney 20e. Method of Disposition 20e. Method of David A. Caney 20e. Method of David A. Caney 20e. Method of David A	4e. Fecility Name (If not institution, give street end nur PLeasant Living Nur 5. Sociel Security Number 6. Sax 465-24-0735 1 M 2 F	Mary Rowell 4e. Fecility Name (If not institution, give street end number) PLeasant Living Nursing Cer 5. Sociel Security Number 465-24-0735 1□ M 2M F 7. Age (In yrs. le 465-24-0735 1□ M 2M F 7. Age (In yrs. le 7. Age (In yrs. le 465-24-0735 1□ M 2M F 7. Age (In yrs. le Mary Rowell Hess 4e. Fecility Name (If not institution, give street and number) PLeasant Living Nursing Center 5. Sociel Security Number	Mary Rowell Hess 4e. Fecility Name (If not institution, give street end numbar) PLeasant Living Nursing Center 5. Social Security Number 465-24-0735 1	Mary Rowell Hess 4e. Fecility Name (If not institution, give street and number) PLeasant Living Nursing Center 5. Sociel Security Number 46.5—24—0735 1□ M 2 E F 7.4 ge (in yrs. lest britidey) 11 Under 1 Year 465—24—0735 1□ M 2 E F 74 Yrs. 10 10 10 10 10 10 10 1	## Ac Fecility Name (if not institution, give street end number) ## PLeasant Living Nursing Center Social Security Number Social Security N	## Ab. City, Town, or Li ## Ab. City, Town or Location ## Ab. City, Town or	Mary Rowell Hess Monthly Name (It not intribution, pive street and number) PLeasant Living Nursing Center S. Sociel Security Number 46.5 = 24 - 0735 10 M 2N F 7.49 (in yrs. hist birnday) 10 Colly, Town or Location of Deeth 10 Colly, Town or Location Deeth 10 Colly, Town or Location 11 Location 12 Was Decodent Ever in U.S. 13 Was Decodent of Hispartic Cripin' (Specify Yes or No Review of American Colly) 10 Colly, Town or Location 11 Location 12 Was Decodent Ever in U.S. 13 Was Decodent of Hispartic Cripin' (Specify Yes or No Review of American Colly) 10 Location 11 Location (Specify or In Planta Status 12 Was Decodent Ever in U.S. 13 Was Decodent of Hispartic Cripin' (Specify Yes or No Review of American Colly) 14 Was Decodent Status 15 Decodent Status 16 Location (Specify or In Planta Maried 20 Location (Specify or In Planta Maried 21 Location (Specify or In Planta Maried 22 Location (Specify or In Planta Maried 23 Location (Specify or In Planta Maried 24 Location (Specify or In Planta Maried 25 Location (Specify or In Planta Maried 26 Location (Specify or In Planta Maried 27 Location (Specify or In Planta Maried 28 Location (Specify or In Planta Maried 29 Location (Specify or In Planta Maried 20 Location (Specify or In Planta Maried 20 Location (Specify or In Planta Maried 20 Location (Specify or In Planta Maried 27 Location (Specify or In Planta Maried 28 Location (Specify or In Planta Maried 29 Location (Specify or In Planta Maried 20 Location (Specify or In Planta Maried 20 Location (Specify or In Planta Maried 20 Location (Specify or In Planta Maried 21 Location (Specify or In Planta Maried 22 Location (Specify or In Planta Maried 23 Location (Specify or In Planta Maried 24 Location (Spec	Mary Rowell Hess Money (Prot Irestation, give street and number) PLeasant Living Nursing Center Biggwater Anne 5. Social Security Number (1 Fact Security Security Number) 46. Page (Pryss. Rest birthopy) 106. Size of December Security Number Security	Marry Rowell Hess Norm Day Year Norm Day Year 1997	

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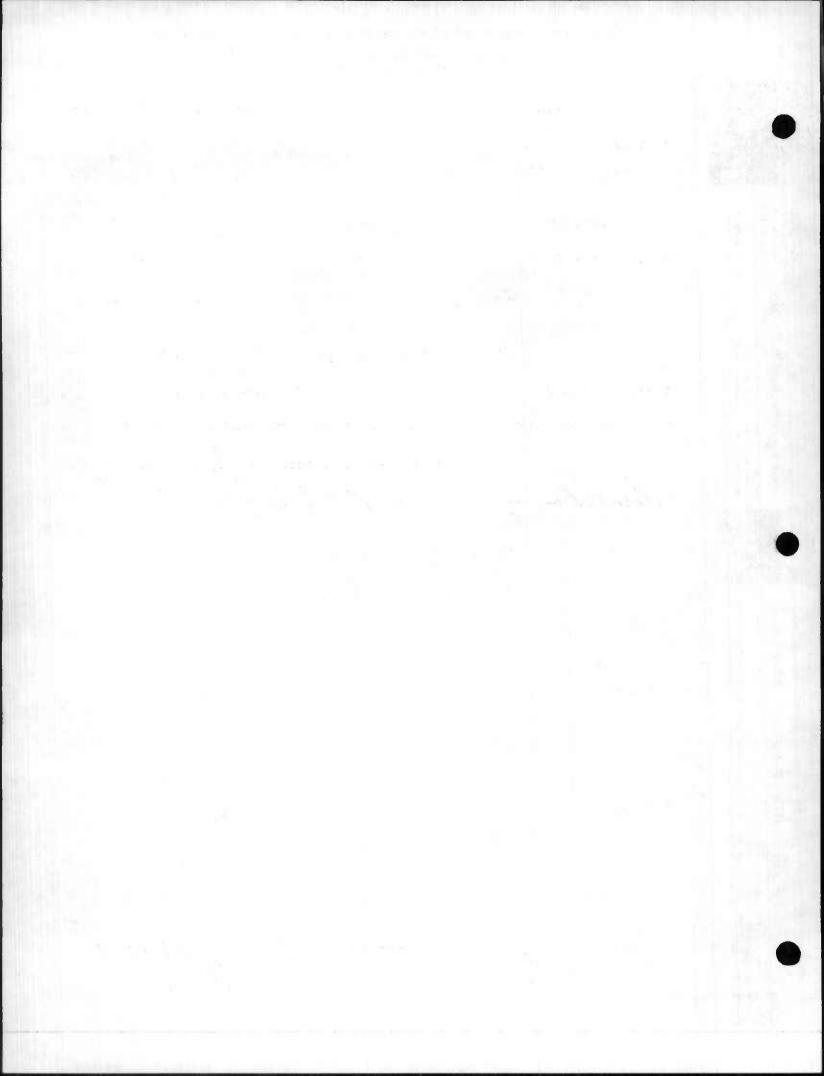


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Day Alfred J. Horrocks November 5:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner | Silver Spring | M | Mours | Min. | Source of Birth (Month, Day, Year) 137 Claybrook Drive Montgomery 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** 1 X M 2 F Yrs. Director 107-12-5331 77 July 17, 1920 New York Usual Residence of Dacedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 137 Claybrook Drive 20902 Funeral USA filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yas 2 □ No If Yes, Give Year or Dates: WW∏ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementery/Secondery (0-12) College (1-4or 5+) Purchasing Agent American University permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be 2 Arthur J. Horrocks Beatrice DeGroot 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jean A. Harrocks (wife) 137 Claybrook Drive, Silver Spring, MD 20902 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) 11/11/97 Alexandria, VA Metropolitan Crematory 21. Signature Funeral Service Licensee 22. Name and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Betw Onsat and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in deeth) Examiner Examiner sician end burial-trensit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical the Due to (or as a consequence of): 98 signed by the end of the detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 D Unknown Records. þ pege 2 should Completed 24e. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of death? 1 Yes 2 H No 1 Yes 2 No of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day Year) the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation death. 2 Accident s efter death 3 ☐ Suiclda 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours el To the Funeral D completely filled 1 Sertifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 36816 10301 30. Name and address of pleted cause of deeth (Item 23a) (Type, Print) 31. Dete filed (Month Day, Yaar) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 7

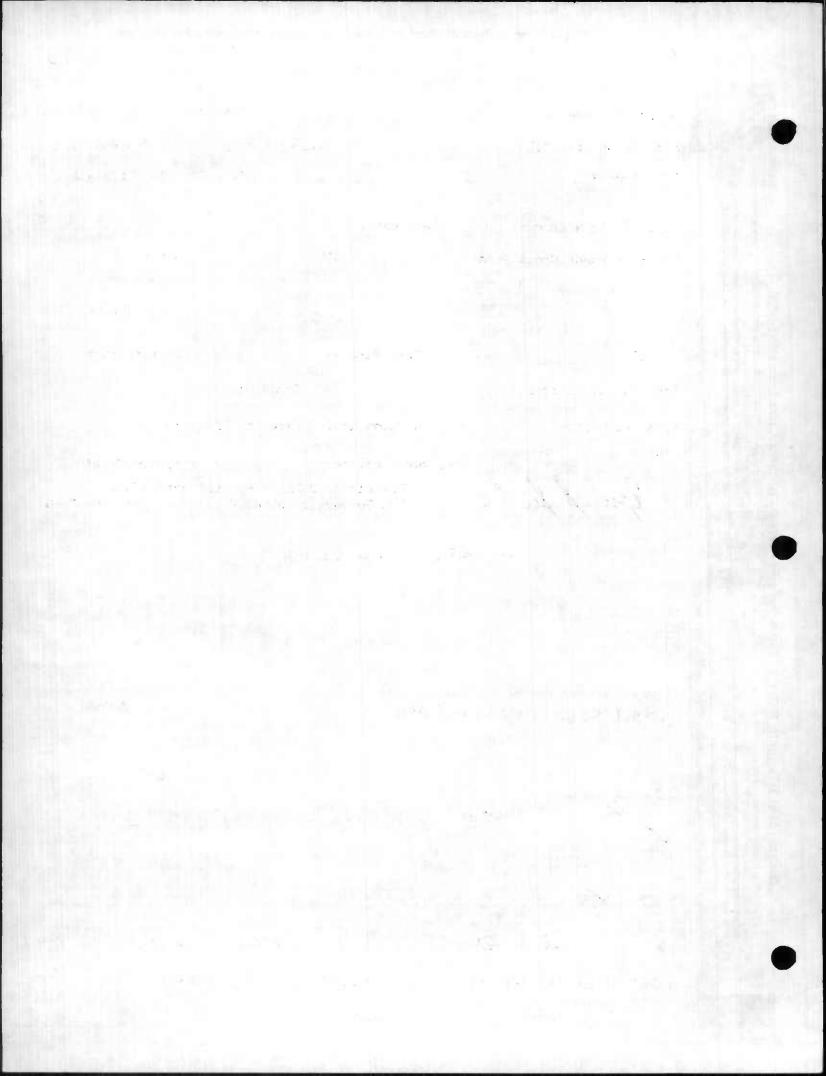
Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 7, 1997 12:55PM Ralph D. Horton /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner | Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date | Months | Days | Hours | Min. | (Mo Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Months 15€M 2□ F Yrs. Director 228-46-9969 59 Feb. 20,1938 Virginia Usual Residence of Dacedent the Marylend r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland | Anne Arundel West River 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours effer death with the and Mentel Hygiene.
7 is marked other than "natural", or itema 23a or 'tranmetic event, the Medical Exercise must be It 5504 East Muddy Creek Road 20778 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify ģ 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16h Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Arboriculture 12 Tree Surgeon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Miller Ecol Phillip Horton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 is m any injury or other traum once. (son) Bergton, Virginia Ralph W. Horton Bergton Road 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 □ Cremation 3 Nemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Robinette Cemetery 11/10/97Fairview, Virginia 22. Name and Address of Facility Blung Francis J. Collins Funeral Home, Inc. 23a. Part 1. Enter the disease, or amplications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate Approximata Interval Batwean Onset and Death **Physiclan** Immediate Cause (Final disease or condition rasulting in death) FAILURE /Medical HEPATIC Examiner Due to (or as a consequence of): Examiner physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be exec Box 68760. Physician/Medical Due to (or as a consequence of) 98 980 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. signed by the a d be deteched f 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown CARCINOMA 1 Yes 2 No SMALL CELL 20 Division of Vital Records. 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? hes page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director. 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) 1 Vas 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Dispetient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death funeral 28d. Describe how injury occurred 28h. Time of Certification: 28c. Injury at Work? After 5 Panding 24 hours efter death. 1 ☐ Yas 2 ☐ No Investigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

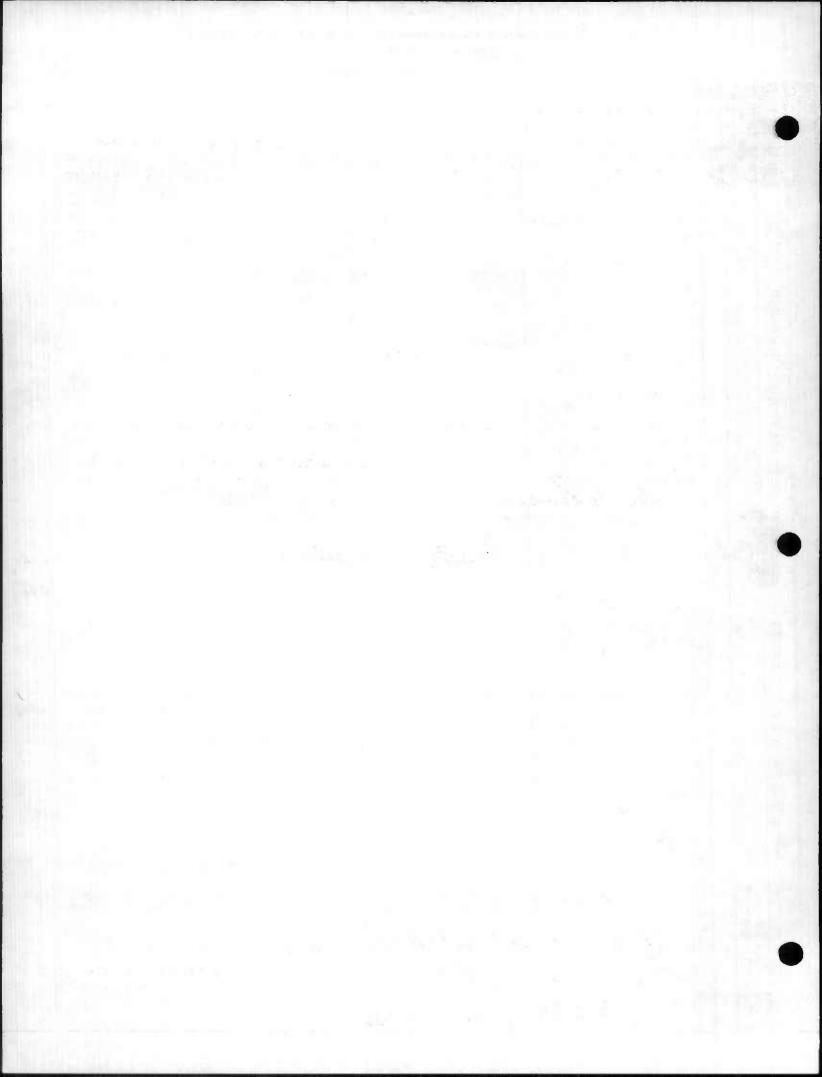
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number -33224 NOVEMBER 07, 1997 (2 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 W Edmonston Dr. ROCKVILLE Mp 20852 TREHAN MO 32. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene

						Cei	rtifica	te of	Death		Re	g. No.	35	980	
Dhuole	ion	1. Decedent's Name (F		2. Dai					1	Year 3	3. Tima of Death				
Physic /Med		Tuyet-Bac					- 3	Month November			12:20 AM				
Exami		4a. Facility Name (If no	t institution, giv	e street end number)				4b. City, Tov	vn, or Lo	ocation of Death	4c. County			
		710 Lowan	der La	ne					Sil	ver	Spring	Mont	gomery	7	
Funeral Director		5. Social Sacurity Numb 219-31-909	1	Sax 7. A 1 □ M 2 🖾 F	ga (In yrs. 76	In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Deta						of Birth h, Day, Year) 29, 1920 9. Birthplece (Stette Country) Vietnam			
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/Medical Examiner	Examiner	Immediata Causa (Fina disaasa or condition rasulting in daath)		b	M	as a consaction as a consactin as a consaction as a consaction as a consaction as a consaction	YICH	ye	loma					6 month	
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within 24 hours To the Funerel completely filled	edicai	one)	Medical Exam	ninar: On the basis of and mannar st	axamınat atad.	ion and/or inv	astigation	, in my o	opinion, daati	n occurr	ed at tha tima, dai	a and place,	and dua to the	causa(s)	
within To the comple	Σ	29b. Signature promitta	of certifiar	210- 4	- 1	24/10/1 12			sa number				d (Month, Day		
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Registr	_	NUV	1 2 19	97 deli	rar's Signa	30.	2.00								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Richard H. Jackson 3:20 AM October 25 1997 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Falston If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) Fallston General Hospital 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sax Birthplaca (Stata or Foreign Country) 1⊠M 2□ F Months Days 217-24-2332 TO Yrs. February 10,1921 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1226 Battery Drive, Havre De Grace, mD Hartond 1 Yes 2 □ No 10e. Straat and Number 10g. Citizen of What Country? Ral Dattery United States Drive 21078 12. Was Decedent Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Orlgln? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Naver Married 2 Married 1 ☐ Yes 2 XNo If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 X No Specify: Specify: Dlack 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Educetion (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) Coilaga (1-4or 5+) VA HOSpital Laundry 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Jackson Howard martha QU DINON 4 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Carrie L. Jackson/ wife 1226 Dattery Dr. Harre De Grace, MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 1⊠Burial 2 □ Cremation 3 □ Bémoval from State 11-1-97 Haure De Grace, MD St. James Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Beard Funeral Home 21. Signature of Funaral Service Mosnes 552 Lew 15 St., House De Grace, MD 21018 Part. Enter the classe, or communications that censed the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. SMALL CELL LUNG CANCER Immediata Causa (Final disaasa or condition resulting in death) Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? NEGATIVE 3 Probably 4 DUnknown 1 Yes 2 No NEUTROPENIA 24b. Were autopsy tindings available prior to completion of ceuse of daath? 24a. Was an eutopsy performed? 1 Yas 20 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medice! 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred 1 Natural 5 ☐ Panding investigation 1 ∏ Yas 2 ∏ No 2 Accidant 6 Could not be datermined

Division of Vital Records, P.O. Box 68760, Jackson this cartificata Richard Aftar

Completed by Physician/Medical Be 2 Certification: Director:

Physician

/Medical

Examiner

Director

Funeral

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Completed

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28a-f s

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traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mantel Hygiene. Important: if item 27 is merked other than "natural", or items 234 any injury or other traumstic event, the Mantel Exercise.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

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24 hours a

within 24 ho To the Fune complataly f

Medical

31. Deta filed (Month, Day, Year) State NOV 7

3 Suicida

29a. Cartifier (Check only

4 - Homicida

29b. Signature and title of certifiar

28e. Piece of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

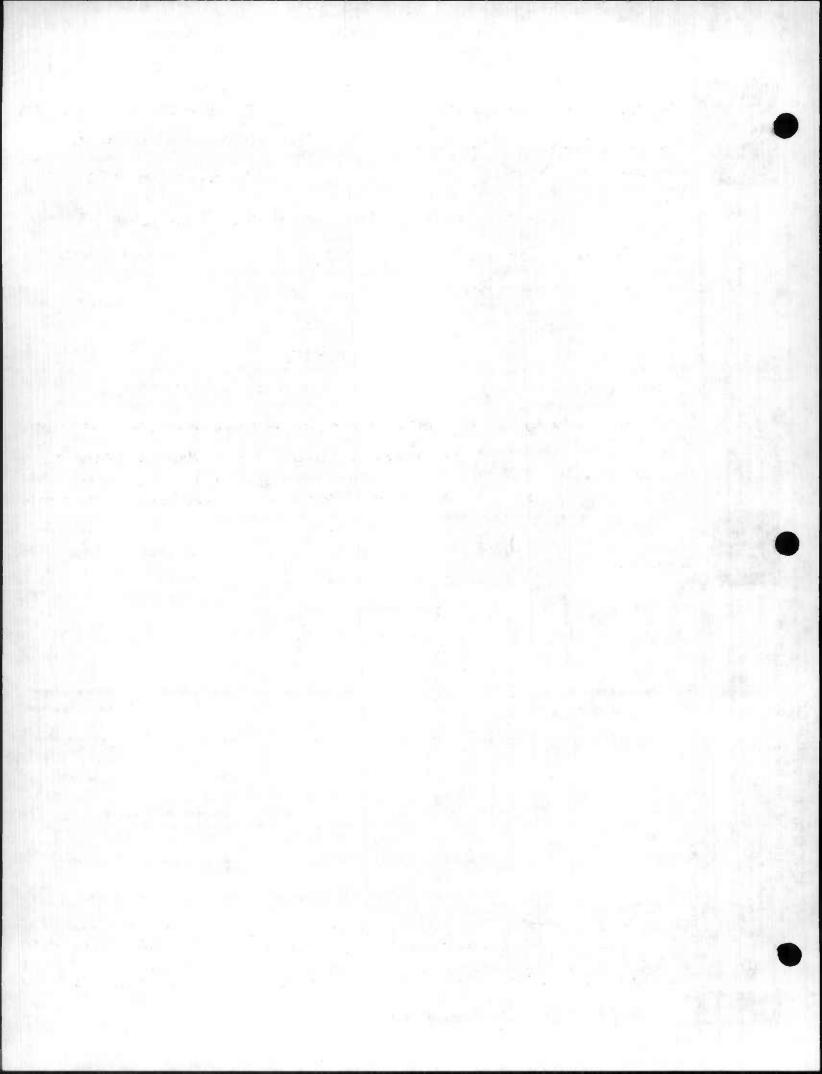
231775 OCTOBER 25, 1997 2012 BEZAR ROAD MANGLANS JOHT 231775

address of person who completed cause of death (Itam 23a) (Type, Print)

32, Registrar's Signature

DHMH 16 Rev 6/95

Registrar



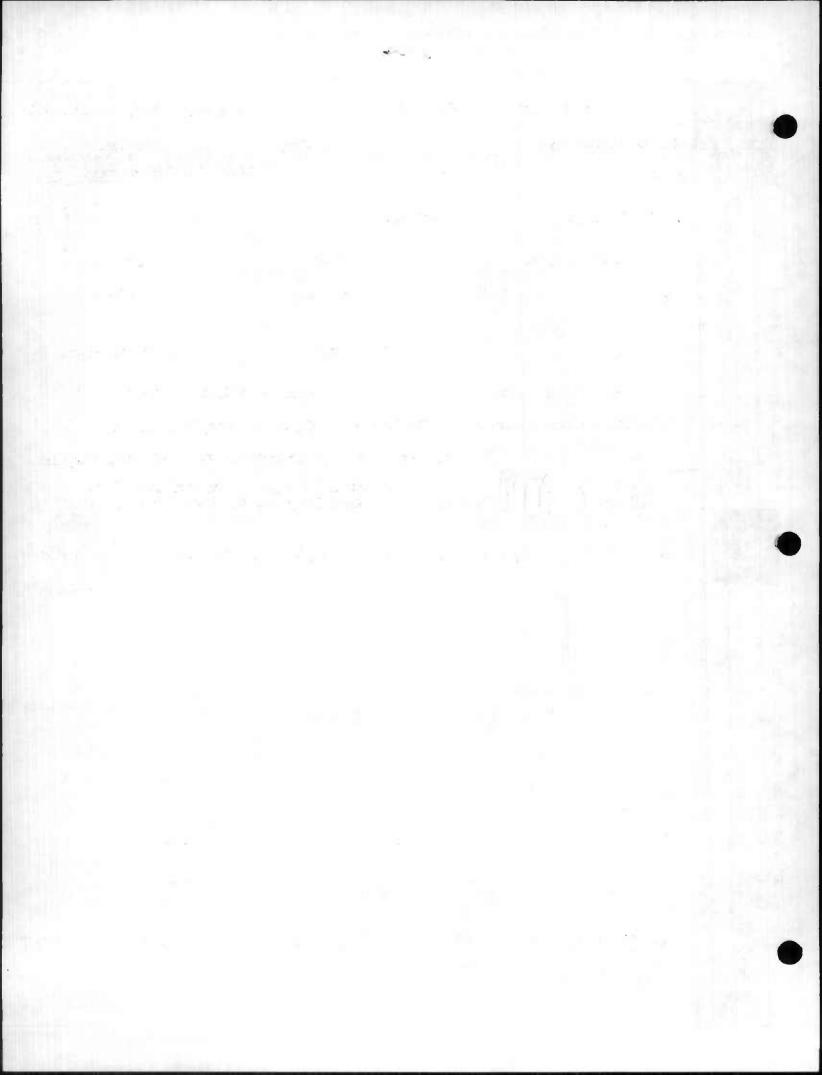
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miner	As To allie Alama Mant Inchieve at a street	a street and nur	m <i>ber</i>)			4	b. City, Town, or Perry	Location of Death Point	4c. Count		
ral tor	000409006	ex M 2□F		s. last birthday) Yrs.	If Under 1 Months	Yaar Deys	If Undar 24 Hrs Hours Min	. (Month, Da	th y, Year) 5,1897	9. Birthp	laca (Stata or For
for	Usual Residence of Decedent 10a. State 10b. County Honfo	ind		ity, Town or Lo		Gro	ace				0d. Inside City Lin
Funeral Director	10e. Street and Number 8305 Post	Road			10f. Zip C	ode	218		10g. Citizen of What Country? United Sto		
2	3 ☐ Widowed 4 ☐ Divorced	12. Was Dace Armed Fo 1 X Yes If Yes, Giv Year or Da	rces?							ca - Americ ck, Whita, y: Blo	
Completed by	15. Decedent's Ed (Specify only highast gra	ucation		16a. Deced (Give life. L	lent's Usual (kind of work DO NOT use	done d	furing most of wo	orking	16b. Kind of B	Unc	
To Be Compl	17. Fether's Name (First, Middle, Last) Alfred O.		SON				18. Mother's Na		inknou	on)	
	19a. Informant's Name/Relationship (1) Alfred W. Johnson		Son					oural Routa Number			Code) 21078
	20e. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Specify	Removal from S	State	Place of Disporcemetery, crem	sition (Name natory or othe	of er plac	e)	Data 11-12-97	20c. Location	- City or To	wn, Stata
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Completed								101	res 210 No	of c	npletion of cause daath?]Yes 2□ No
To Be	25. Was case referred to medical examiner?	Hospital: 1 □ Ir	npatient 2	ER/Outpatient	3□ DOA	Othe		ath (Check only o		ar (Specify)
Medical Certification: To Be (27. Menner of Death 1 Naturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		h, Day Year)	28b. Time of injury	М			28d. Describe i	now injury occur	red	
al Certifi	4 Homicide determined	buildin	ig, etc. (Speci				e date and place	City or Tox	m, State)		Route Number,
Medical	(Check only one) 2 Medical Exam	iner: On the ba	SIS OF EXAMINE	ation and/or inv	estigation, in	my op	inion, deeth occi	urred et the time,	date and piece,	and due to	the ceuse(s)
	Mirark				D2:	icansa 177	number		29d. Data signe		
	30. Neme and address of person who o	ompieted cause	of death (Ite	m 23a) (Type, F	Print)						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 35683 State of Maryland./ Department of Health and Mental Hygiene

					Cer	tificate of	Death	Re	g. No.			
Dhualai		1. Decedent's Name (First, Middla,	Last)		138	1-		2. Data of Death Month	-	Year	3. Time of Death	1
Physici: /Medic		FRED	DOUGLAS	JO:	HNSON			Novembe:			1:10 PM	1
Examin		4a. Facility Name (If not institution,	give street and numbe	or)			4b. City, Town, or	Location of Death	4c. County	of Death		
		412 Dembytown F	load	14			Joppa		Ha	rford		
Funeral Director		5. Social Security Number 214-30-4350 Usual Residenca of Decedent	3. Sex 7. / 1 1 M 2 □ F		last birthday) 4 Yrs.	If Under 1 Yaar Months Days		8. Data of Birth Month, Day Feb. 14	, 1933	9. Birthple Count Mary	ace (State or Forei py) Land	ign
rland ow		10a. State 10b. County		10c. City	y, Town or Loc	ation				10	d. Inside City Limi	lts
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or 28	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of V	Vhat Count	ry?	
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01		6 Dherr	en n	Car		D	31856		NOV	101	Th. A9	7
X	-	30. Name and address of person wh	o completed cause of	death (Item	23e) (Type P					101	.,),,,,	1
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DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death November 12, 1997 Stanley Jacobson 11:35 PM 4e. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 8501 Meadowlark Lane Montgomery Bethesda 6. Sex 1 DM 2 □ F If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociei Security Number 9. Birthpieca (Steta or Foraign Country) Mary Tand 7. Aga (In yrs. last birthday) 75 Yrs 125-22-0800 Usuai Rasidenca of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8501 Meadowlark Lane 20817 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: WW I I Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5+ Psychologist self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meldan Surnama) Samuel Jacobson Ida Berman 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) (wife) Olive Jacobson 8501 Meadowlark Lane, Bethesda, Maryland 20b. Plece of Disposition (Neme of camatery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 11-13-97 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth immediate Cause (Final disease or condition resulting in death) Imonths ung (ancer Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Lest Due to (or es e consequenca of) Due to (or es e consaquanca of): Part il. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 | Yee 2 | No 3 □ Probably 4 ☑ Unknown 24e. Wes en eutopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case reterred to medical exeminer?
1 ☐ Yes 2 ☒ No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner ot Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) D23600 November 13, 1997 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Hospital or Attending Physician: The law requires that the death certificate be executed Zahours after deeth.

24 hours after deeth.

Pureral Director: After this certificate has been signed by the ettending physician end setsy filled in by the funeral director, page 2 should be deteched for use es the buriel-transit Division of Vital Records, P.O. Box 68760. To the Hospital within 24 hours a To the Funeral C completely filled

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6

items 23s

permit. Pages 1 and 2 should be filed within 72 hours effer death 1 Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 222 any injury or other traumatic.

Physician /Medical

Examine

Examiner

Physician/Medical

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Be

Certification: To

Medicai

page 2

Baltimore, Maryland 21215-0020

Director

Funeral

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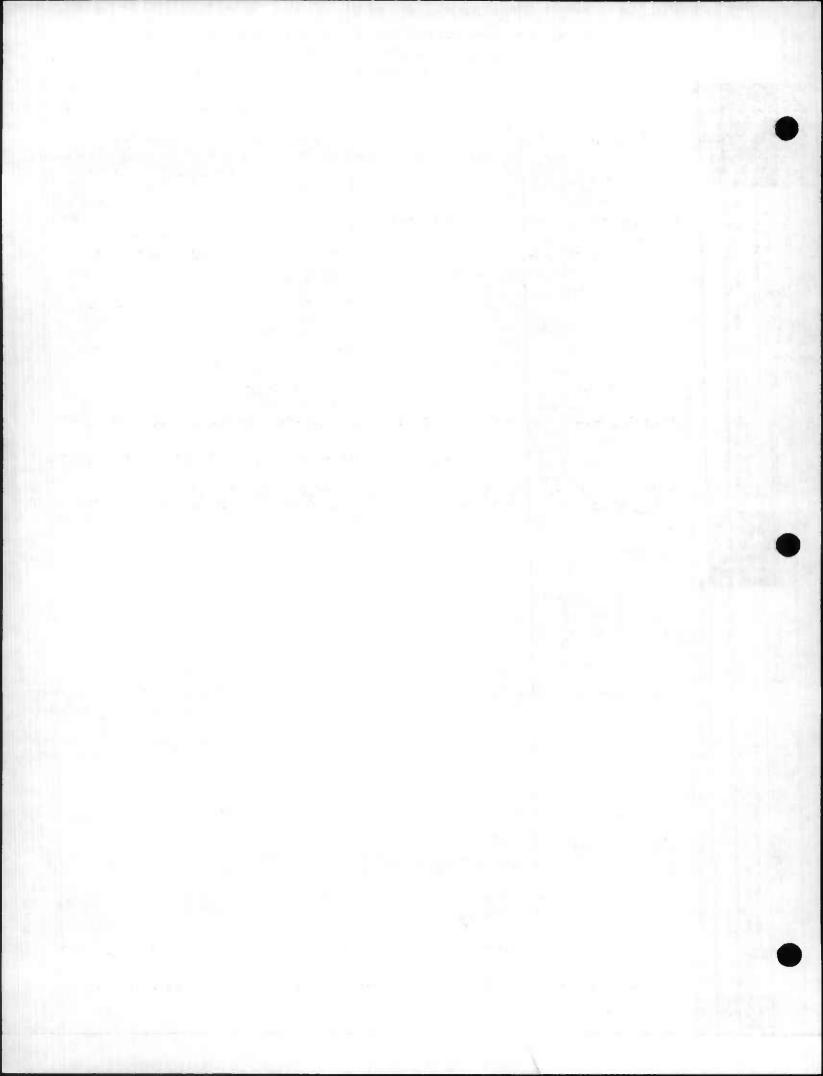
Completed

traumatic event, the Medical Examiner name be notified at

State Registrar 32. Registrer's Signeture

Bruce R. Kressel, M.D., 2141 K Street, N.W. #707, Washington, D.C.

12

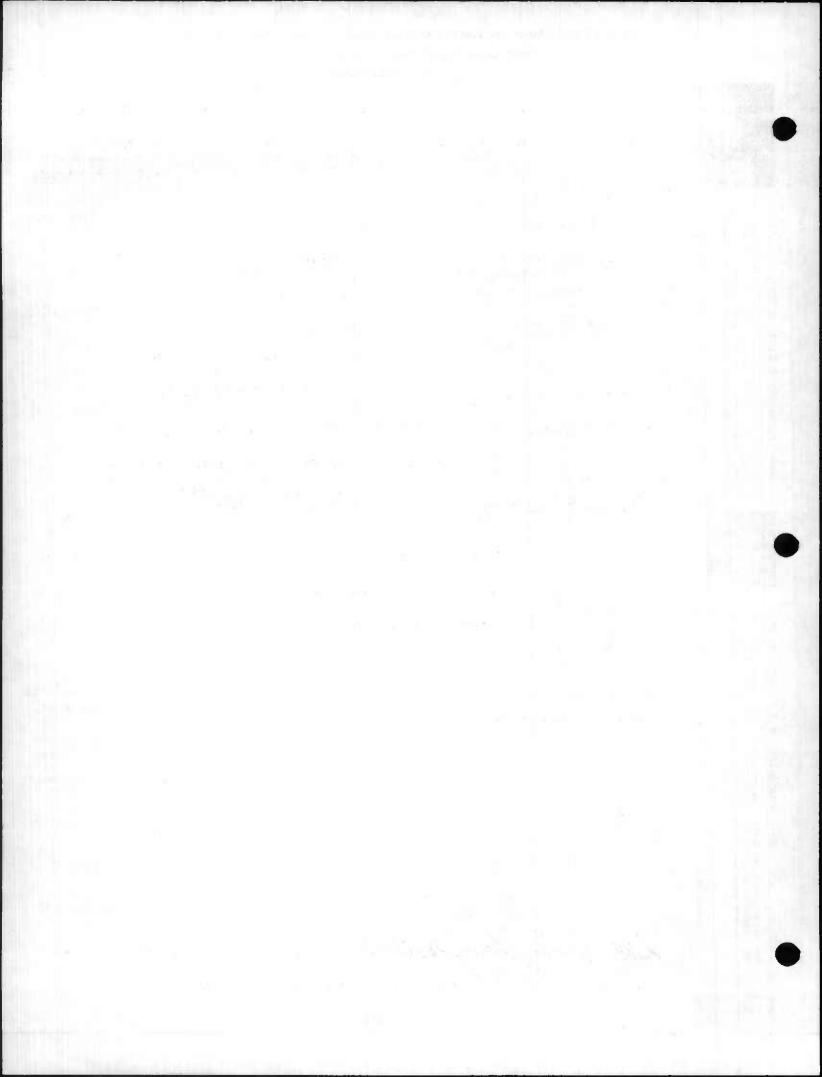


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month Emma Jarrett November 7:30 /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mediplex of Montgomery Village Gaithersburg Montgomery 8. Data of Birth (Month, Day, Year) April 10, 1915 Pennsylvania 5. Social Sacurity Number If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF 577-42-8139 82 Yrs. Director Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be not lied at Director 1 ☐ Yas 2 ☑ No Montgomery North Potomac 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? death with 12016 Winesap Terrace 20878 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No if Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event, the Medical Exercises. 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: þ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Elementary/Secondery (0-12) College (1-4or 5+) Retail Sales Auditor Retail 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be 2 Earl Clarence Georg Edith Isabel Hartley 19a. Informent's Name/Ralationship (Type, Print) (SOII) 19b. Mailing Addrass (Street end Number or Rurel Routa Number, City or Town, Stata, Zip Coda) Robert D. Jarrett, Sr. P.O. Box 5306, Laytonsville, MD 20882 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 11/15/97 Rockville, MD Parklawn Memorial Park 22. Nama and Addrass of Facility Francis J. Collins Funeral 21. Signatura of Funarai Sarvica Licensaa 500 University Blvd. West Home, Inc. Bru Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete intarval Between Onsat and Death **Physician** /Medical Immediata Cause (Finel Acute Renal Failure 2 weeks diseesa or condition rasulting in daath) Examiner Due to (or as a consequence of) Examiner Embolus to renal arteries 2 weeks requires that the death certificate be axecuted burial-transit Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of): and P.O. Box 68760, attanding physician for use as the buria Chronic atrial fibrilation 2 years Physician/Medical Dua to (or as a consequanca of): Pert il. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 Probably 4 ⊠ Unknown Cerebral infarct with hemiplegia Division of Vital Records, þ page 2 should b 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy The law After this certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa refarred to medical 26. Piece of Death (Check only ona) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatlant 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral 27. Mannar of Daath 28e. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: 28d. Dascriba how injury occurred 5 Panding Invastigetion 1 (ZNatural 1 ☐ Yas 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Sulcida 28f. Location (Street and Number or Rural Route Numbar, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homleida 15 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the ceuse(s) and mannar as stated.
2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the tima, data and place, and due to the cause(s) and mannar stated. Medical 29a. Cartifier (Check only one) 29b. Signature and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) November 12, 1997 D12121 30. Nama and addrass of person who completed causa of death (item 23a) (Type, Print) George F. Sengstack, 3929 Ferrara Drive, Wheaton, MD 20906 32. Registrar's Signatura State Tulia Davidson Registrar

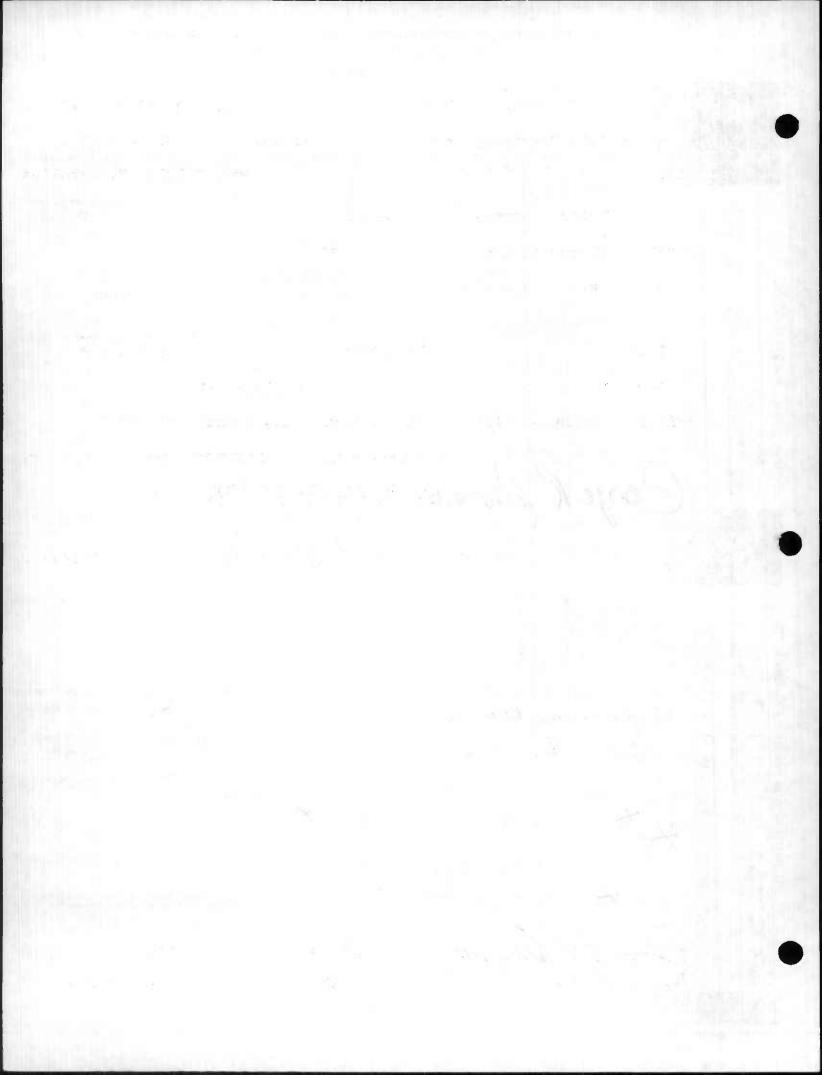
DHMH 16 Ray 6/95



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State of Maryland / Department of Health and Mental Hygiene 97 35686

				(Certificate	e of Death	F	leg. No.	33000
Physiciar	n	Decedent's Name (First, Middle, Last					2. Date of Dee		3. Time of Deeth
/Medica	al			NSON			NOV.	10°, 19	
Examine	r	4e. Facility Neme (If not institution, give	CO THE STREET				r Location of Death		
		Golden Oaks No 5. Sociel Security Number 8. Se			day) If Under	Laure			E GEORGES 9. Birthplace (State or Foreign
Funeral Director			M 2□ F 87	Yn	Months	Deys Hours Mi	n I (Monto, Day	,1910	Country) S. Carolin
show		10e. State 10b. County		ity, Town o		. 7			10d. inside City Limits
28a-f sho	901		Georges		Laure				12⊠ Yes 2□No
ms 23a or 28a-f show	Funeral Director	8715 Mulberry			10f. Zip	20707		U.S	
alt, or its	2	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? PLYS 2 No If Yes, Give Yeer or Detes:	J,S.		ent of Hispenic Origin? (ify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		- American indian, k, White, etc. Black
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Pan Pan	Completed	Elementery/Secondary (0-12)	College (1-4or 5+)						Georges
tygie nt. m		12th 17. Fether's Name (First, Middle, Last)		W	atchma			School	
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M Merk	0	19e. Informent's Name/Relationship (T)		10h M	Agiling Address	(Street end Number or F	sha Wel		State Zie Codel
trau		Wilma D. Johnson				perry St.,			
of Hee		20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ F		Piace of D cemetery,	isposition (Nem	e of her place)	Date		City or Town, Stete
ant: h		4 □ Donation 5 □ Other (Specify)		D Ve	terans	Cem	11/17/9	7 Crow	wnsville, M
Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic avent, the Managare.		21. lignature of Funeral Service License	Suon	lou	SNOWD	Address of Facility EN FUNERA ILLE, MD	L HOME, 20850	P.A.	
		234 Part Enter the Press, or compleshock, or heart of are. List only or	ic ons thet caused the dea	th. Do not			ac or respiretory en	est,	Approximate Interval Between
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/Medicai xaminer		immediate Ceuse (Final disease or condition resulting In death)	Carur	nen	a df	he place	tato		10-15-789
		resulting in death)			nsequence of):				
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physician and sthe burial-transit	EXai	Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (or es e cor	nsequence of):				
sicla e bur		thet initiated events	Due to /	01 8 2 2 20	sequence of):				
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seen s hould	bieten	Sque D	esarle				24e. Was e perfor		24b. Were autopsy findings available prior to completion of cause of death?
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otor,	13	25. Wes case referred to medical examiner?				26. Place of De	eath (Check only or	10)	
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fter th ineral	5	27. Menuer of Deeth 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	e of 28	Bc. injury at Work?	28d. Describe h	ow Injury occurre	d
deeth.	200	2 Accident Investigation			М	1 Yes 2 No			
		3 ☐ Suicide 6 ☐ Could not be determined	28e. Piace of Injury - At I building, etc. (Special	iome, farm	, street, factory,	office	28f. Location (S City or Tow		r or Rurel Route Number,
frer deeth. iractor: Affei in by the fune	0	29a. Certifier Physics							
vurs efter deeth. araf Diractor: After t filled in by the funer.			sician: To the best of my known or the basis of exemine	owledge, detion end/o	eath occurred a r investigation,	it the time, date and pled In my opinion, death occ	e, and due to the c surred et the time, d	ause(s) and man ete end piace, si	ner as stated. nd dua to the cause(s)
24 hours efter de Funeral Diracte etely filled in by t		(Check only 2 Medical Examin	and manner stated						
vithin 24 hours effer de o the Funeral Directe ompletely filled in by the Medical Certific	edicai		and manner stated.		29c.	License number	2	9d. Date signed	(Month, Dey, Year)
within 24 hour To the Funer completely fill	edicai	(Check only 2 Medical Examination)	and manner stated.				2	9d. Date signed	(Month, Dey, Year)
within 24 hours effer do To the Funeral Direct completely filled in by t	medical	(Check only circle) Medical Examination (Check only circle) (Check	and manner stated.	m 92el (T	1	License number	2	9d. Date signed	(Month, Dey, Year)
	medical	(Check only 2 Medical Examination)	and manner stated.	m 23e) (Ty	pe, Print)			11/2/97	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 5/2 Kaur November 9 1997 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOSPITAL SHADY GROVE ADVENTIST ROCKVILLE MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG. 1, 19 5. Social Security Number Birthplace (State or Foreign Country)
 INDIA 1 M 2 F Months Days 213-92-9556 81 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. MONTGOMERY GAITHERSBURG 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 11024 OUTPOST DR. 20878 INDIA Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Specify 3 ₩Widowed 4 Divorcad ASIAN 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) TA HOUSEWIFE HOME 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) UNKNOWN SINGH UNKNOWN 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BISCAYNE LA., DAMASCUS, MD. 20872 AMARJIT BAKSHI/ SON 9904 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlai 2 DICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 11-11-97 RIVERDALE, MD. 21. Signature of Funarai Sarvice Licenses 22. Nama and Addrass of Facility MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) e. Acute Myocardial infarction Omin ulmonary years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown mellitus 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? 1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other (Specify) 1 Inpatient 2 SER/Outpetient 3□ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

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"natural", or Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after beautiment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or han any injury or other traumatic.

Baltimore, Maryland 21215-0020

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treumstic event, the Medical Examiner must be notified at

Physician/Medical Examiner by Completed Be Certification: To

physician and s the burial-transit requires that the death certificate be executed 2 signed t certificate this After after deeth.

I Director: After din by the fur Medicai

P.O. Box 68760. Records, Division of Vital Hospital or Attending Physician: To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by

> State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. iabetes 25. Wes case referred to medical examiner? examiner? 28a. Date of injury (Month, Dey Yeer) 27. Manner of Death 28c. Injury et Work? 5 Pending Investigation 1 Naturel 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piaca, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and mannar stated. 29a. Certifier

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Data signed (Month, Day, Year) November 9, 1997

29b. Signatura and titia of certifier

ames

Brookes Ave Gaithers burg mo 20877 207 3700 31. Date filed (Month 32. Registrar's Signature

Fulia Davidson

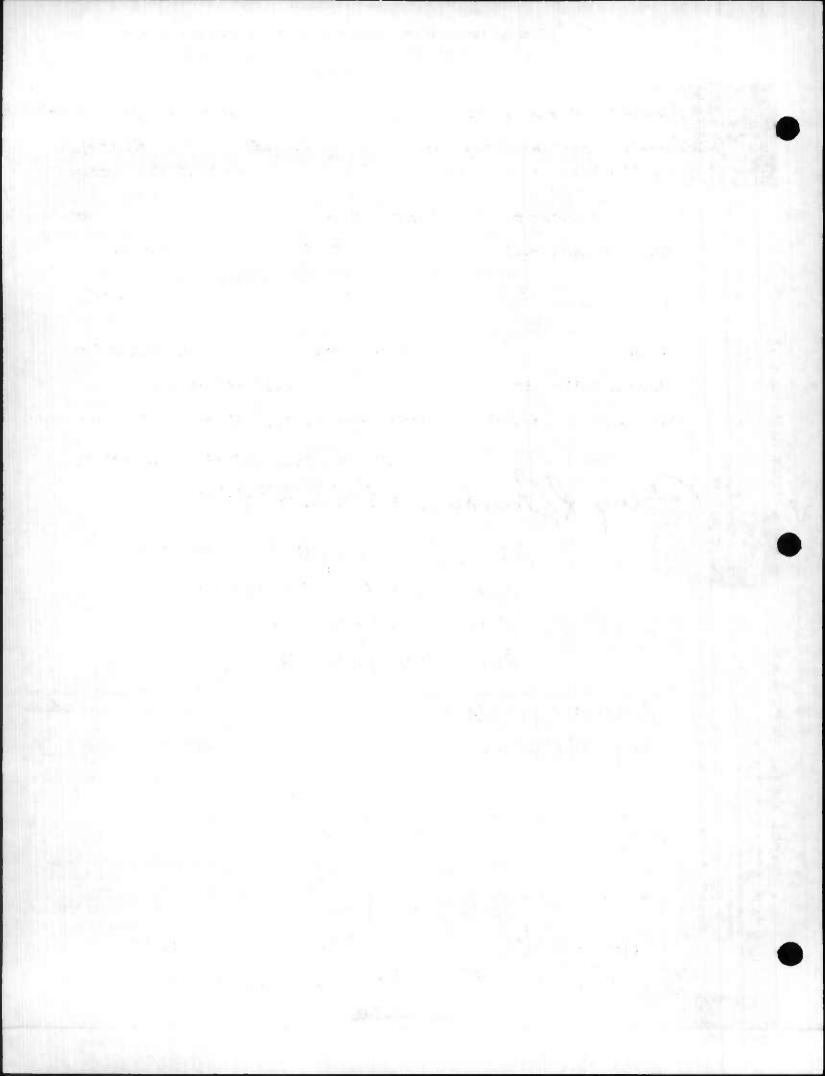
ALCREA THE RELIEF Your called AT THE MEDICAL STREET the court of the said of the court of to produce process and the second state of the and the second of the second o

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Defe of Deeth 3. Time of Deeth Month **Physician** Kelly, JR NOV. 12 /997 4c. County of Deeth 0950 / VORMAN /Medical 4a. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth Examiner Georges AUCE EGIONAL pormel If Under 24 Hrs. 8. Dete of Birth
(Month, Day, Year)
May 16, 1932 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) 9 Birtholece (State or Foreign **Funeral** Months Min. Devs Hours M A D F Maryland 220-28-6187 65 Yrs. Director Usuel Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinat must be notified at MD Montgomery Spencerville XXYes 2 No Director the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20868 16513 Batson Road U.S.A. Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stefus XXYes 2 □ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or Specify: Black 1 ☐ Yes 2 No Specify: à 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Heelth and Mentel Hyghens Important: If Itam 27 is marked other than on any Injury or other traumatic event Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver Construction 17. Fether's Neme (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Sumeme Be Norman Kelly, Ella Henderson 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ella Kelly (Daughter) 3532 Peartree Ct., Silver Spring, MD 20906 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donetion 5 □ Other (Specify) Nat'l Mem. Park 11/18/97 Laurel, MD 21 Signature of Funeral Service Ligaria 22. Name end Address of Fecility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, y one cause on each line. 23a. Pert1. Enter the disease, or shock, or heart failure. List or Approximate fntervel Between Onset end Deeth **Physician** /Medical fmmediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Examine physician and the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest P.O. Box 68760. thet the death certificate be Physician/Medical Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown signed bedet Records, λq 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peed 1 □ Yes 2 □ No certificate Division of Vital Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient Medical Certification: To 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral To the Hospital or Attending PI within 24 hours effer death.
To the Funeral Director: After it completely filled in by the funera 27. Menner of Deeth 26b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) in 24 hour.
The Funeral Dire.
Triflied in by 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture end title of cartifier 29d. Dete signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 14201 Laurel Park Dr. Laurel MD. 20707 01.0 IW ALA 32. Registrer's Signature 31. Date filed (Month, Day, Year) State NOV 14 1997 Registrar

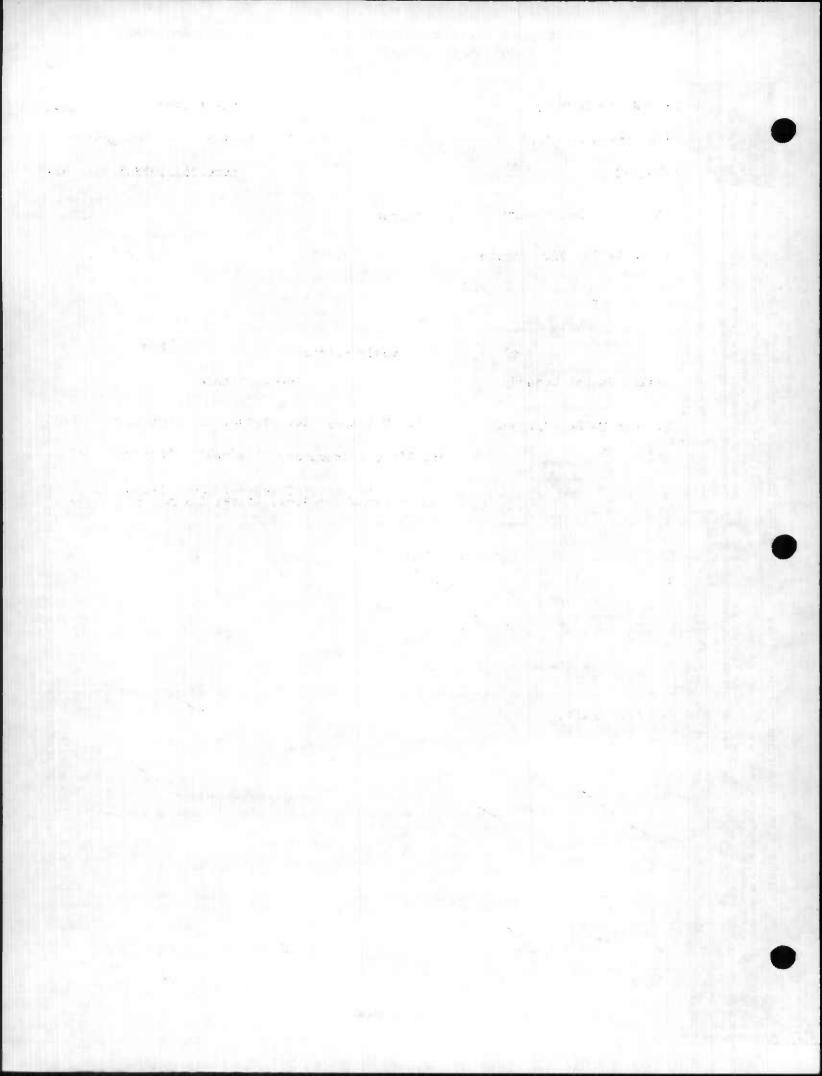


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Mary Agnes Kennedy Nov 4,1997 1:40am /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery if Under 1 Year 8. Data of Birth (Month, Day, Year) Aug. 15, 1925 5. Social Sacurity Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 24 F Months Days Hours Min 72 Yrs. 487-28-0595 Missouri Director Usual Residence of Decedant with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ahow treumatic event, the Madical Examinar name be notified at MD XXYas 2 No Montgomery Kensington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11210 Valley View Avenue 20895 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Yaar or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 2 should be filled within 72 hours after and Mental Hygiene.
Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: white þ 3 Widowed 4 XXX Worced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) Music music teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) Be Leslie Joseph Kennedy unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other treum page. 11210 Valley View Avenue, Kensington, MD B. Joan Tolbert/friend 20b. Plece of Disposition (Nama of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 🖾 Kremation 3 ☐ Removal from State 11/6/97 Brentwood, MD Ft. Lincoln Crematory 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Seprice Li 22. Name end Address of Facility 11800 New 20904 Hines-Rinaldi Funeral Home, 11800 Hampshire Ave., Silver Spring, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Ventricular Examiner Due to (or as a consequenca of) Examiner MI ettanding physician and for use as the burial-transit certificate be axecuted Sequantially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 4cars Box 68760 Physician/Medicai Due to (or as a consequenca of): 23b. Did tobacco use contributa to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 100 signed by 1 Tes 2 No 3 Probably 4 Unknown TUNITE BM p Records, 8 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed has 1 Yas 2 11100 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 hpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: ii or Attending F s after death. ii Director: After After 1 Divatural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide To the Hospital o within 24 hours at To the Funeral D 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 43510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THERESA & Milliamy hin, 8700 GLOXGIA AVY, STYUV, SILVE SPIMG, 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV12 Wie Davidson Registrar

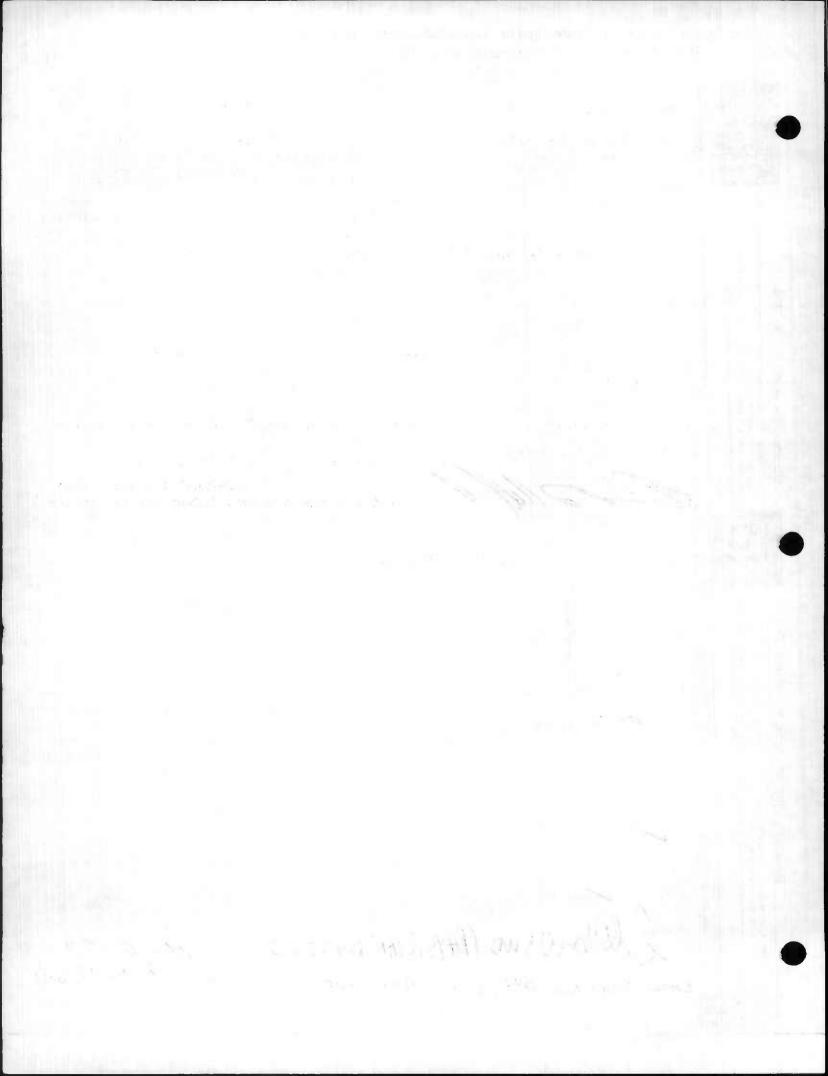
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State of Maryland / Department of Health and Mental Hygiene 97 35690

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Exam			olgate War								cation of Deeth Spring	,	of Deeth	mery
Funer Direct		5. Social Security I		Sex 1□M 2∰ F	7. Age (In yrs	s. lest birth	Mo	Under 1 Year onths Deys		24 Hrs. Min.	8. Dete of Birt (Month, De Novemb	v. Year) er9,191	g. Birthp Court 1 Kor	oleca (Stete or Foreign ntry) Cea
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th with the 23a or 28	Funeral Director	10e. Street end Nu 13630		Way Ap	t. #71	1	10	0f. Zip Code 20904				10g. Citizen of Whet Country?		
21215-0020 d within 72 hours after death with the Maryland glene. writhen "naturel", or freme 23e or 28e-f show then "naturel" at the Maricel Examiner must be notified at	þ	11. Marital Status 1 □ Never Man 3 □ Widowed	ried 2 Married	12. Wes Dece Armed For 1 Yes If Yes, Giv Yeer or Da	rces? 21 No e	U,S.	If Yes	Decedent of s, specify Cul res 2 \(\text{No.}	ben, Mexican	i, Puerto	ecity Yes or No Rican, etc.)	Bie	ce - Americ ck, White, V: As 1a	
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dea ctor	Certification:	2 Accident 3 Suicide 4 Homicide	investigetion 6 Could not be determined	e 28e. Plece	of Injury - At I ig, etc. (Spec	nome, fern					28f. Location (5 City or Tox	Street end Numb n, Stete)	er or Rure	el Route Number,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physiclan** Day Year ARVIL (MMN) LYON 4:05 P.M. October 30, 1997 /Medical 4a. Fecliity Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 1701 Mountain Road Harford Joppa | If Under 1 Yaer | If Under 24 Hrs. | 8. Deta of Birth (Months, Day, Year) | Feb. 6, 1920 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign Country) North Carolina **Funeral** 1 XM 2□ F Yrs. Director 241-22-2751 Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f ahow ahow 1 ☐ Yes 2 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with r than "natural", or items 23s or the Medical Examiner must be 1701 Mountain Road 21085 USA Funeral 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Rece - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 ☐ Yas 2 ZNo If Yes, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 21215-0020 1 Yas 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) Hygiene. Self-Employed Drywall Contractor Construction .. Pages 1 end 2 should be filed w trnant of Heelth and Mental Hygien tant: If frem 27 is marked other th jury or other traumatic evant, in Maryland 17. Fether's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be F. G. Bonnie (nmn) Holcomb 19a. Intorment's Name/Raiationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Elsie M. Lyon - Wife 1701 Mountain Road, Joppa, Maryland Baltimore, 20a. Mathod ot Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removal from Stata permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) Mt. Christian Church Cem. 11-4-97 Joppa, Maryland 21. Signature of Funaçai Sarvice Licani 22. Name and Addrass of Facility
Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Pert1. Enter the disaesa, or complications at caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only of cause on sech line. Approximata Intervel Batw Physician /Medical Immediate Causa (Finel . NOW SMALL CELL LUNG CANCER 12 months disaasa or condition rasulting In daath) Examiner Examiner ACHEXIA The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Diseasa or Injury that initiated evants resulting in daath) Last Dua to (or as a consequence of): and the buriel-tran Box 68760 Physician/Medical Dua to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contributa to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown CACEMIA à ate has been signated bage 2 should b Completed 24a. Was en autopsy performed? 24b. Wara autopsy tindings aveilebla prior to completion of causa of daath? certificate has 1 ☐ Yas 2 No 1 Yas 2 No Physician: Be 25. Wes casa raferrad to medical 26. Pleca of Death (Check only ona) Hospitel: 1 | Inpatlant | 2 | ER/Outpetient | 3 | DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 8 ☐ Othar (Specify) 2 1 ☐ Yas 2 No this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima ot Certification: 28c. Injury at Work? 28d. Describe how injury occurred Aftar Attending 1 Netural 5 Panding Injury death. 1 ☐ Yas 2 ☐ No 2 Accidant Invastigation efter death in by the 6 Could not be datarminad 3 ☐ Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicida 5 within 24 hours e To the Funeral C completely filled the Hospital 1 Certifying Physician: To the bast of my knowledge, daeth occurred at tha time, dete end place, and due to tha cause(s) and manner es stated.

2 Medical Examinar: On the basis of axamination end/or invastigetion, in my opinion, daath occurred at tha time, deta and place, and dua to the cause(s) end mannar stated. 29a. Certifier Medical (Check only one) 29b. Signatura and titla ot cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) nis Shaling 10/31/97 30. Nama and address of person who complated causa of daath (Item 23e) (Type, Print)

DESH SHARMA, MD 1814 BIELAIN RD FAUSTON MD 21047

31. Data tiled (Month, Day, Year)

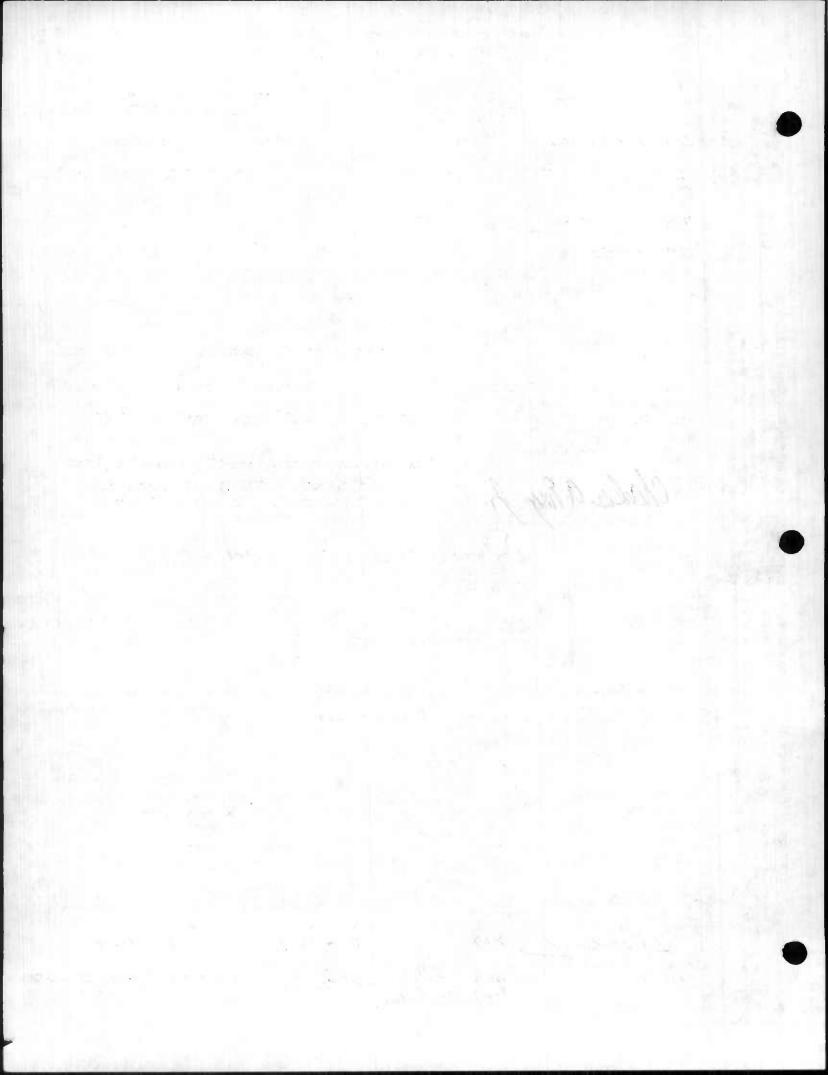
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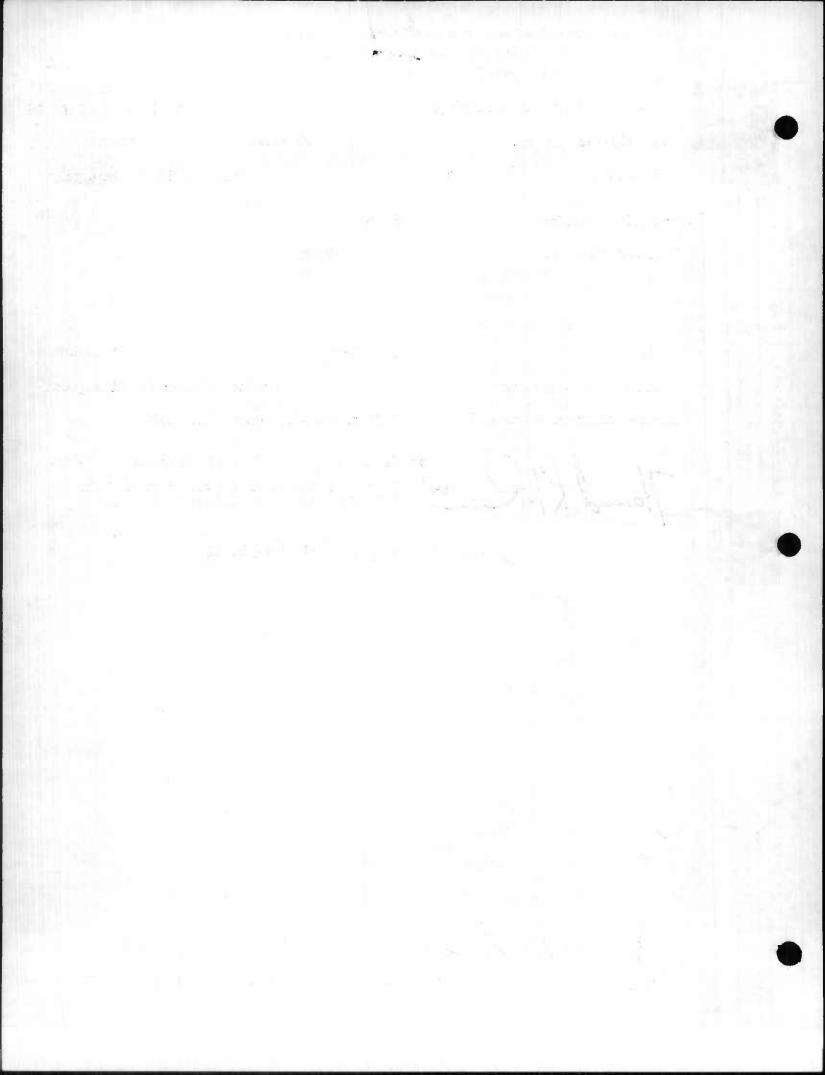
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State of Maryland / Department of Health and Mental Hygiene 9 7

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the F	19s. Intormant'a Name/Ralationship Breece Leftridg				18. 1410(1)	Martha				naston
	Breece Leftridg	-	196	. Mailing Addre	ess (Street and Numb					3
5				_	ockton Rd.			21085		000)
the tr	·			Disposition (f		Date		. Location -	City or Tow	n, Stata
eny Injury or	1 ■ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other Spe			s Cemet		11-8-	.07 71	ordec	n Ma	ryland
niu e	21. Signe ur of Funeral Service Li	deroted ()	Daker		and Address of Facil		-91 AU	Derdee	al, Ma	тутана
ong a	1 / tamas	ME	4		d K. McCo Cokesbury					
	23a. Part1. Enter the disease, or los shock, or heart failure. List or	omplications that caused to	he death. Do i							Approximete ntervat Between
niner	disease or condition resulting In deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Oue to (or es a d	consequence o						
Medicai	Cause (Disease or thjury that initiated events resulting in death) Last	cD	ue to (or as a c	consequenca o	f):					
of for use	Doct II Other designation of the									
h h	Part II. Other algnificant conditions	a contributing to death but	not resulting in	the underlying	g cause given in Part	1. 23	b. Did tobed	,		he cause of deat bly 4 - Unknown
be de										
Completed						24	e. Was an au performed		avall	e autopsy finding abte prior to pletion of cause eath?
Be Com							1 🗆 Yas	2 0 No	1 🗆 🕆	Yes 2□ No
	25. Was case reterred to medical exeminer?				26. Ptac	e ot Death (Chec	k only one)			
	1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Ou	tpatient 3	DOA Other: 4 N	ursing Home 5-6	Residence	6 □Othe	r (Specify)	
	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of tnjury (Month, Day	Year) 28b. 1	ime ot njury	28c. Injury at Work?		scribe how in	njury occurre	ed	
Certification:	2 Accident invastigat 3 Suicide 6 Could no 4 Homicide determine	t be	y - At home, fa (Specify)	rm, atreet, tact	1 ☐ Yes 2 ☐ ory, office	28t. Loc	eation (Street or Town, St		er or Rural F	Route Number,
dical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Phyalcfan: To the best of caminer: On the basis of a and manner state	xamination and	, death occurred/or investigation	od at the time, date ar on, in my opinion, dea	nd plece, end due ath occurred et the	to the cause e time, date	e(s) and mar end placa, a	nner es stat nd due to th	ed. he cause(a)
eldmoo	29b. Signatu and title of cartitier	1		. 2	9c. License number		29d.	Date signed	(Month, Da	ay, Year)
	home	la Si	VT	(9)	D 330 €	99	11	619	7	
3	30. Name and address of person wh	no completed cause of dea	13 %	Type, Print) _				- 4		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Fiber **Physician** Catherine Elizabeth Lochary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street end number, Examiner Iorien Riverside Nursing & Rehab. Ctr. Belcamp athorine 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 217F Months Deys Hours **Director** 217-01-2517 Usual Residence of Decedent April 29, 1916 Maryland 10a. State 10b. County 10c. City. Town or Location traumatic event, the Medical Examiner must be notified at Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a 1702 Emmorton Road 21014 Funeral USA 14. Race - American Indien, 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Y Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 ☑ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) d 2 should be filed within 72 h end Mental Hygiene. 7 is merked other than "ru Elementary/Secondery (0-12) College (1-4or 5+) U.S. Government Secretary 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Frederick Stephen Lochary 2 Clara Isabella Poole 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Depertment of Health e important: If itam 27 is any injury or other trau 207 A. Crocker Drive, Bel Air, Maryland 21014 Julia L. Boggs - Sister 20b. Piaca of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Deuriai 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Ignatius Cemetery 22. Name and Address of Facility 11-3-97 Hickory, Maryland Howard K. McComas III Funeral Home, P.A. 23a. Pert1. Enter/the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate Approximate Approximate Approximate Approximate **Physician** /Medical LIVER DISEASE. Immediate Cause (Final disease or condition resulting in death) Examiner ALPHA - ONE ANTI - TRYPSIN DEFICIENCY Due to (or es e consequence of): Due to (or es e consequence of): Examiner ician end buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last HRONIC OBSTRUCTIVE Palmonary DISCOSE physician the burie an/Medical 88 950 Physici signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, P.O.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

23b. Did tobacco usa contribute to the cause of death? No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

one month

0006

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2√2 No

XIa1

1 Yes

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

1 Yes 2 No 27. Manper of Death 28a. Dete of Injury (Month, Dey Year) 5 Pending Investigation Naturel
2 ☐ Accident

6 Could not be determined

28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner as stated.

[2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred at the time, date end pieca, and due to the ceuse(s) end manner stated. 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Dey, Year) UCTOBER

DR Stanley

Business Center Way Suite 102 Edgewood

Registrar

10

p

Completed

Be

P

Certification:

Medical

3 ☐ Suicide

4 Homicide

31. Date filed (Month, Dey, Year)

Division of Vital

After

death. after death Director:

To the Hosp within 24 hor To the Fune completely fi

ò Hospitai 24 hours a 24 hours Funeral

ve day its unit in our STATE OF STA The state of the second of described and the state of the second section of the section of t William programme a programme of the contract of the American The second of th

	hysician /Medical Examiner
=	

1. Decedent's Name (First, Middle, Last)

1997

Funeral Director

the Maryland 72 hours efter

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at d 2 should be filed within 7; th end Mental Hygiene. 7 Is merked other than "na permit. Pages 1 end 2:
Depertment of Heelth el
Important: If Item 27 Is
any Injury or other trait

Baltimore, Maryland 21215-0020

SH

Physician /Medical Examiner

that the death certificete be executed end ettending physician for use es the burie the the 2 signed bed t page 2 should b certificate director this After deeth.

P.O. Box 68760, Records, Division of Vital Hospital or Attending Physician: ofter deeth Director: A d in by the f To the Hospital c within 24 hours e To the Funeral C completely filled

2. Date of Death Day Month TVAN LEROY LIMBERT NOVEMBER 7 20:12p 4a. Facility Nama (If not Institution, give street and number) 4h City Town or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar. 24, 1918 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1₩ M 2□ F 79 Yrs. 197-09-7466 Pennsylvania Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1407 Old Joppa Road 21085 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 20 Married 1 X Yes 2 No If Yes, Give Year or Dates: WW II by Specify: 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 Mail Carrier U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Arthur Henry Limbert Mamie May Shomper 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informent's Name/Relationship (Type, Print) Elsie A. Limbert - Wife 1407 Old Joppa Road, Joppa, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 11-10-97 Bel Air, Maryland 22. Name end Address of Facility
Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 23a. Pert1. Enter the disease, or complications that sused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause of each line. Approximata Interval Between Onset and Death Immediate Cause (Finel TRAUMATIC BRAIN INJURY disease or condition resulting in death) 4 DAYS Dua to (or as a consequance of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the causa of death? 1 Yee 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1□ Yes 2⊞ No 1 □ Yes 2 No Be 25. Was case refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☒ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending Injury 1 Yes 2 No 3 97 13:00 Investigation 2 Accident FALL FROM LADDER

29a. Certifier

31. Date filed (Month, Day, Year)

NOV₁

6 Could not be datermined

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and due to the cause(s) and manner as atated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signatura end 14th of certifie

29c. License number RES-000

29d. Data signed (Month, Day, Year) NOVEMBER 7, 1997

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1407 OLD JOPPA RD/JOPPA, MD

30. Name and addrass of parson who complated causa of death (Itary 23a) (Type, Print) N WOLFE ST/BALTIMORE, MD 21287

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
AT HOME

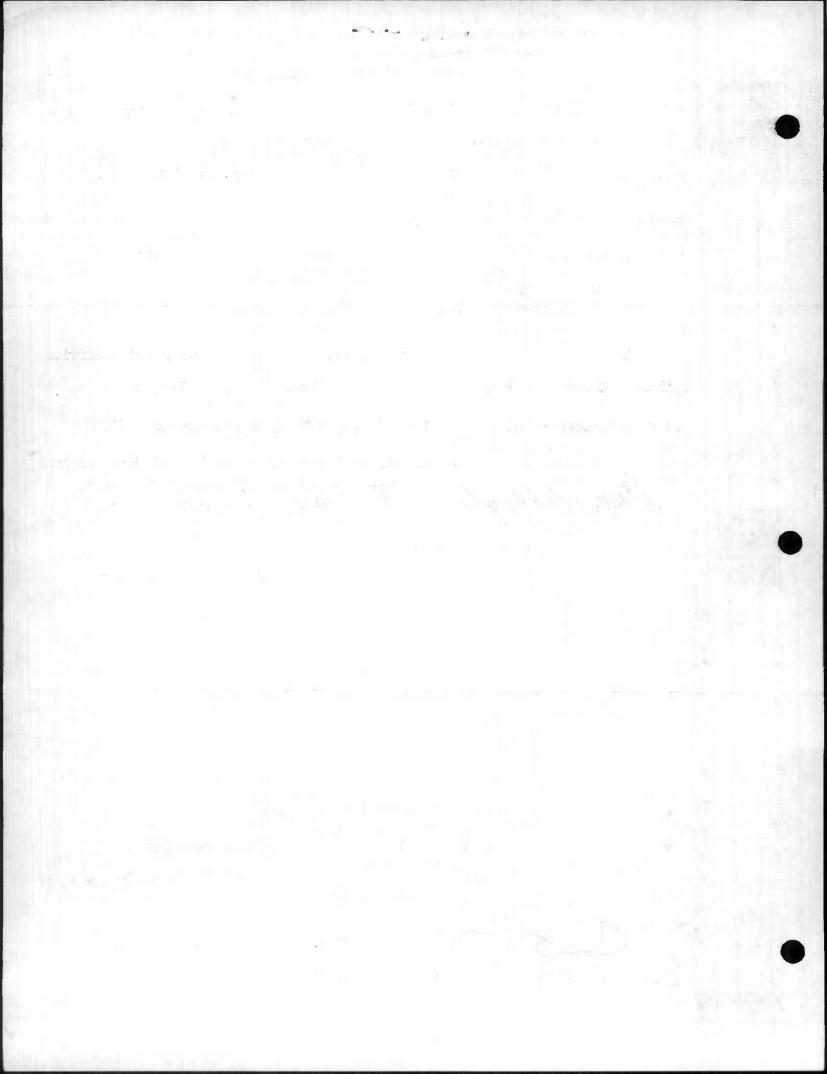
State Registrar

edical

32. Projegrar m Signature

DHMH 16 Ray 6/95

10+1



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth JOSEPH G. LITTLE Month 10 5:50 am te. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 1416 Whiteford Road Harford Street If Under 24 Hrs. Hours | Min. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 6. Sex 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys 1 X M 2 ☐ F Yrs. 244-22-4486 72 April 30,1925 N.C Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 21KINo Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1416 Whiteford Road 21154 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 TryYes 2 □ No It Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 Yes 2X No Specify: Specify: White WW II 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Supplies College (1-4or 5+) 12 Sales Manager Lumber/Building 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Joe O. Little Bessie Pearl Gilley 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ruth Little - Wife 1416 Whiteford Road, Street, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removel from State Darlington Cemetery 11/13 4 ☐ Donetion 5 ☐ Other (Specify) Darlington, MD 21. Signeture of Funerel Service Licens 22. Name and Address of Fecility Harkins Funeral Home, Inc., Delta, PA 234 Fert1. Errer me disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximate Intervel Betw Metastatic Malignant Melanoma Immediate Cause (Final year diseese or condition resulting in death) Due to (or es e consequence of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were eutopsy tindings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

or 28a-f show

items 23a

should be filed within 72 hours after and Mental Hygiene.

merked other than "natural", or its

Pages 1 and 2 should be finant of Health and Mental I not: If Item 27 Is marked of

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

Funeral

by

Completed

Be

Examiner Physician/Medicai by Be 10

sician and burial-transit been signed by the s should be detached page 2 this in by the funeral After To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fo Medicai

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Hospital or Attanding Physician:

death.

Completed Certification:

0

27. Manner of Deeth

2 Accident

4 Homicide

3 ☐ Sulcide

29a. Certifier

29b. Signeture end title of cartifier Sohbay Parks, MD

28e. Dete of Injury (Month, Dey Year)

29c. License number

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.
2 Medicat Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year)

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

11/10/97

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

so HYANG PARK, Battimore Veterans Administration Hospital. 10N st. Baltimore. 31. Dete tiled (Month, Day, Year) 32. Registrer's Signature

State Registrar

NUV1 3 1997

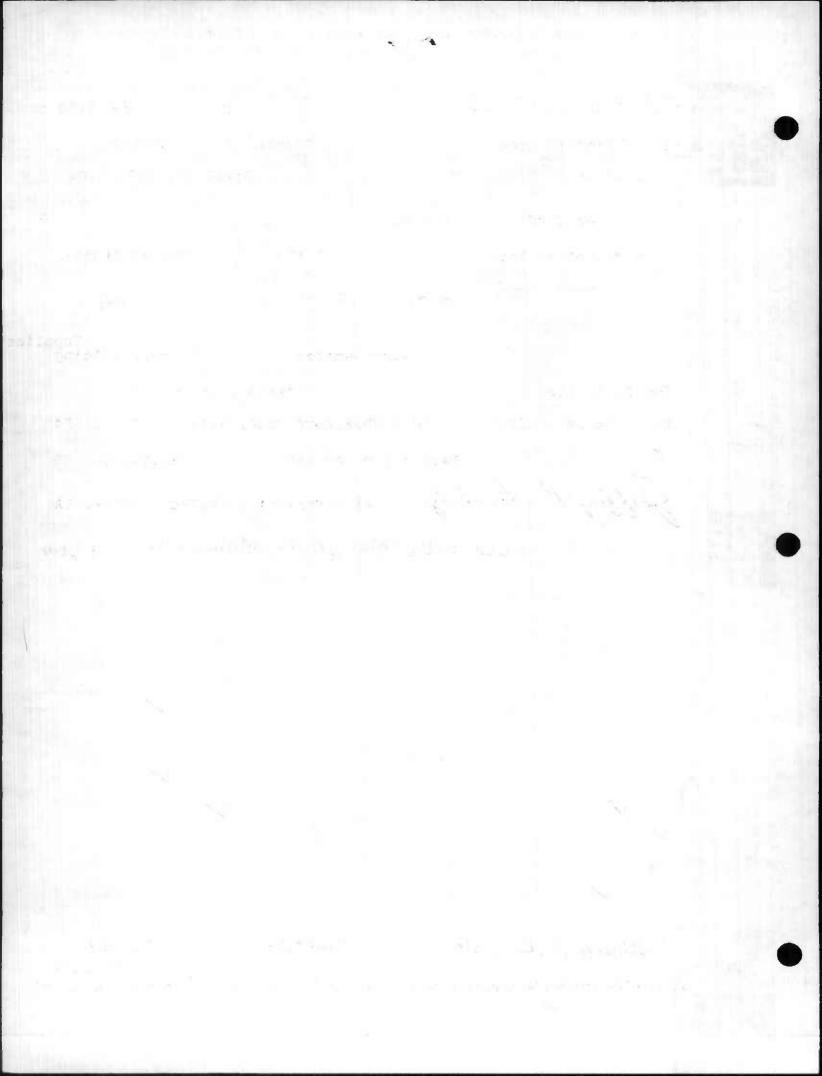
5 Pending Investigation

6 Could not be determined

sta davideor Reveall

28b. Time of

28e. Plece of injury - At home, tarm, street, factory, offica building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

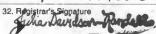
State of Maryland / Department of Health and Mental Hygiene

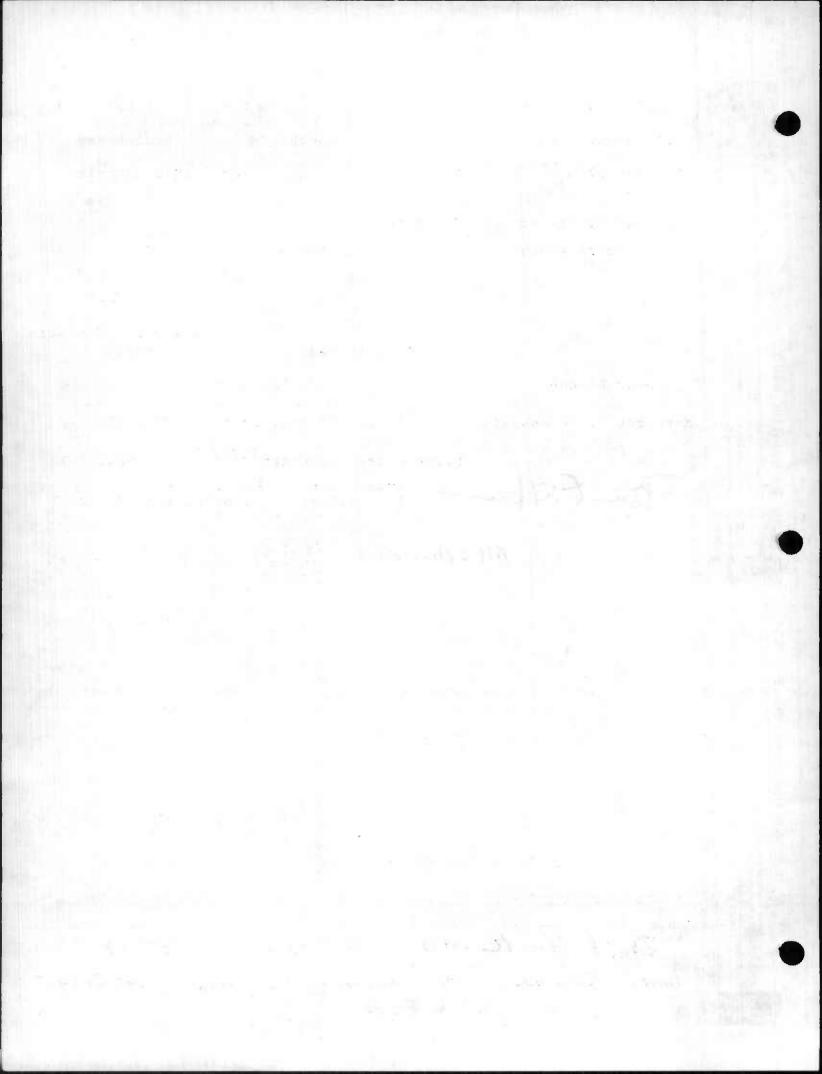
Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth **Physician** Month Allan David London 4, Nov. 1997 8:40am /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 9915 Edward Avenue Bethesda Montgomery if Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs, lest birthday) Birthplece (Stete or Foreign Country) **Funerai** Deys Hours XXM 2 F 48 220-56-5976 Yrs. Director Mar.1,1949 Maryland Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 9915 Edward Avenue 20814 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 □Yes 2 □XNo If Yes, Give Yeer or Dates: 1 ☐ Yes 2 ☐ No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Insurance/Financial Elementery/Secondary (0-12) College (1-4or 5+) Service Self-Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Seymour London Barbara David 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret M. London/Wife 9915 Edward Ave. Bethesda, MD 20814 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial ②Cremetion 3 ☐ Removel from Stete Metropolitan Crematory 11/7/97 4 Donetion 5 Other (Specify) Alexandria, VA 22. Name end Address of Fecility
Ives-Pearson Funeral Home p of Funeral Service Cit Wilson Blvd. Arlington, 22201 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediete Cause (Finel MECANOMA disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): signed by the a Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 2 XNO After this certificate 1 Tes 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA If Director: After this ad in by the luneral of 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Sulcide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) end manner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end pleca, and due to the cause(s) end menner stated. Medical (Check only 29b. Signeture end title of certifier 29o. License number 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) DANIEL ROSENBLUM, MD 10400 CONNECTICAT DE KENSINGTON, MD 20895

State Registrar 31. Dete filed (Month, Dey, Year) NOV 12 1997





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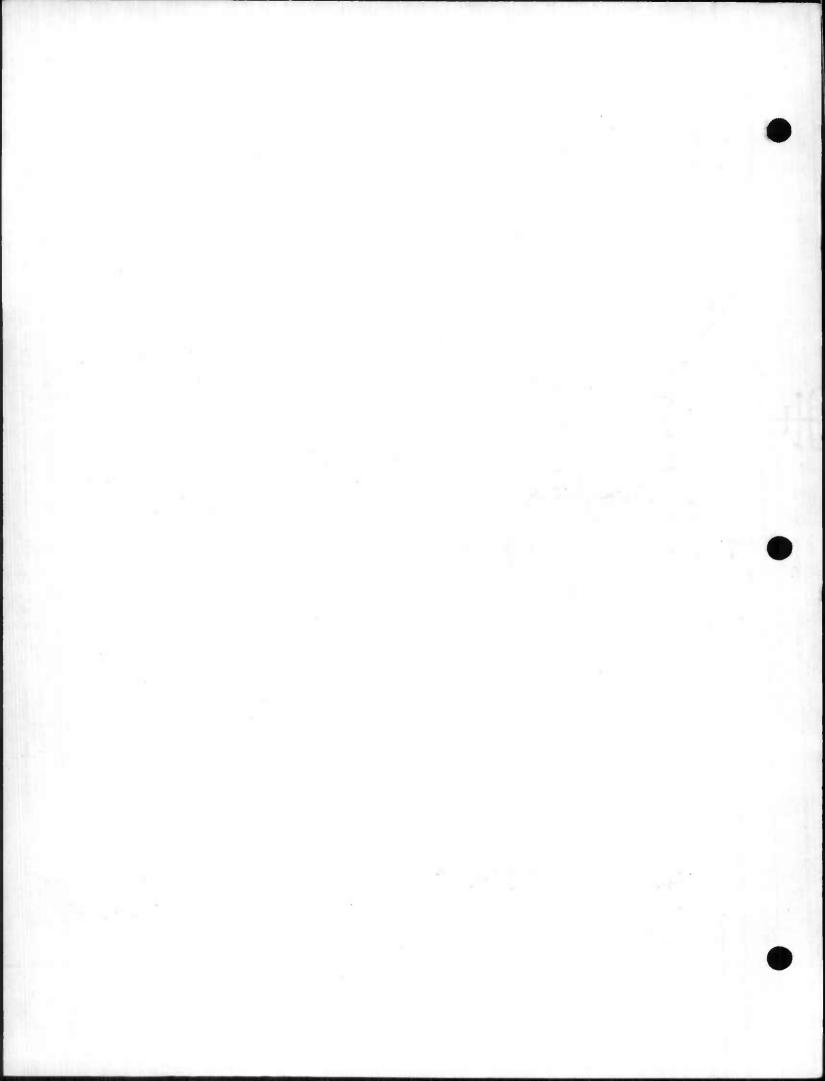
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buntal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIEN	VI
C	ERTIFICATE	0	F DEAT	ГН		REG. NO	٥.

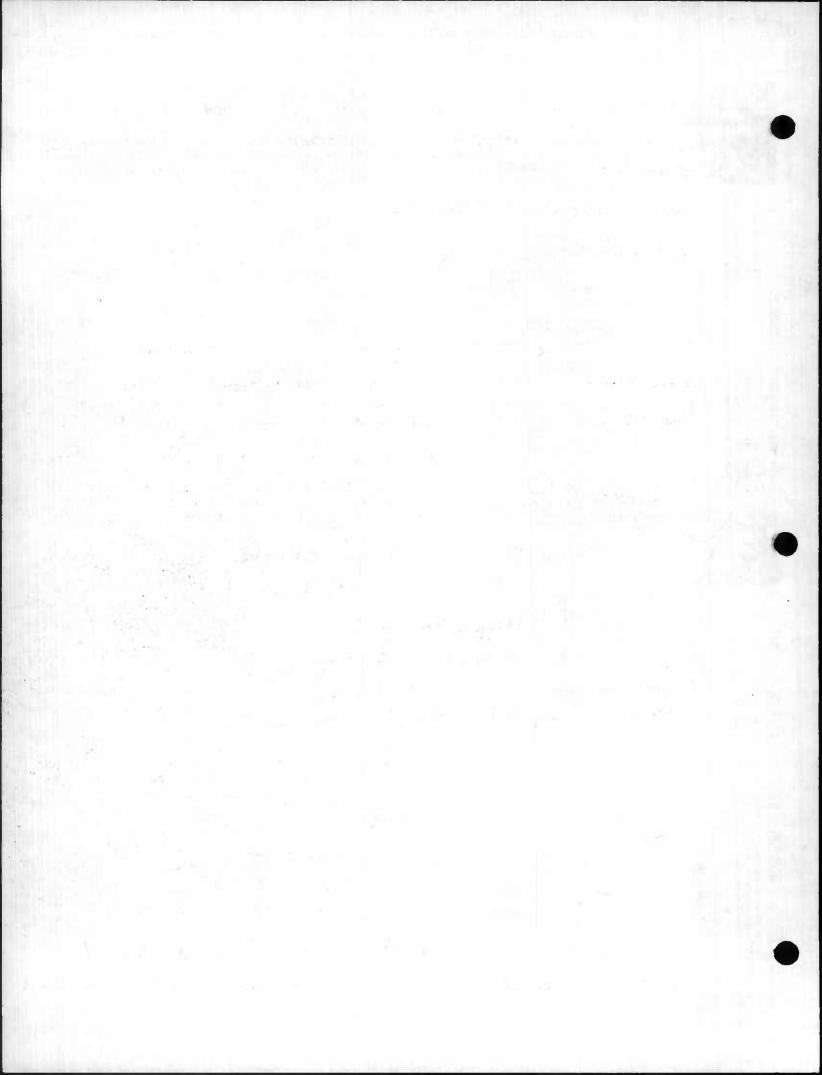
4.	1 - STATE REGISTRAR	STATE OF MARY		TMENT OF I		MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last) MARY ELI	ZABE	TH	LAI	KE	2. DATE OF DEATH DA	\$ 5	3. TIME OF DEATH
			(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTNPLACE (State or Foreign Country)
	562-26-2347	☐ M 2 🖾 F	83 yrs.	MONTHS DAYS	HOURS MIN.	Dec. 25,		Colorado
	9s. FACILITY NAME (If not institution, give street			9b. CITY, TOWN	OR LOCATION OF DE	ATN	9c. COUNTY	OF DEATH
OR	2445 Lyttonsville R	.oad		Silver	Spring		Montg	omery
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c CIT	Y, TOWN OR LOCA	TION			10d, INSIDE CITY
DIRECTOR	CA Santa	Cruz		Santa Cr				LIMITS?
	10e. STREET AND NUMBER	OL UZ			I. ZIP CODE		10a. CITIZEN	1 ☑ YES 2 ☐ NO
RA	3400 Paul Sweet Ro	ad B308		"	95065			USA
FUNERAL		. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC		IIC ORIGIN? (Specify Yea	1	RACE — American Indian,
BY FI	1 Never Merried 2 Merried 3 M Widowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, sp		n, Puerto Rican, etc.)		Specify: White
0	15. DECEDENT'S EDUCATION (Specify only highest grade com		16e. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BUS	SINESS/INDUST	TRY
E		college (1-4 or 5+)	life. Do NOT us		ist or working			
APL		4	Owner/M	anager		Dres	s Shop	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Maiden	Surname)	
BE (Madison Slaught	er			Sarah	Reddick		
TOE	194. INFORMANT'S NAME (Type/Print)		196. MAILING	ADDRESS (Street	and Number or Rural F	Route Number, City or Town	n, Stata, Zip Coo	ole)
F	Walter C. Lake	(son)	610 K	napp Str	eet, Yre	ka, CA 96	097	
	20s. METHOD OF DISPOSITION 1 □ Burial 2 ☑ Cremation 3 □ Removal	from State	b. PLACE AND DATE	OF DISPOSITION (N	ame of	DATE 20c. LO	CATION — City	or Town, State
	4 Donalion 5 Other (Specify)		metery, crematory or o	tan Crem	atory	11/9/97	Alexan	dria, VA
	21. SIGNATURE OF FUNERAL SERVICE LICENS	mc l				Inc. 500 MD 2090		ollins rsity Blvd. W.
CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	•	A CONSEQUENCE O	F): F):	NFAR	RCT18 1		Interval Between Onset and Daath
AL C	PART II. Other significent conditions of	ontributing to death	but not resulting	in the underlyin	g ceuse given in	Part I, 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS
						1 YES 2	J.	COMPLETION OF CAUSE OF DEATH?
AEC								1 YES 2 NO
 Z	DID TOBACCO USE CONTRIB	UTE TO CAUSE	OF DEATH Y	ES NO [UNCERTAIN	V X		
ZIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA					
SIC		OSPITAL:	tpatient 3 DOA	OTHER: 4 Nursing Hor	ne 5 Residence	6 Other (Specify)		
BY PHYSICIAN: MEDIC	27. MANNER OF DEATH 1. Netural 5 Pending 2 Accident Investigation	25s. DATE OF INJURY (Month, Day, Year)		JURY W	JURY AT DRK? YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCUR	RED
COMPLETED B	3 Suicids 6 Could not be 4 Homicide determined	25e. PLACE OF INJUR building, etc. (Sp	IY — At home, ferm, ecify)	street, factory, offi	:0	26f. LOCATION (Street : City or Town, State)	and Number or i	Rural Route Number,
PLE	29e. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the best of my kno	wiedge, death occurr	ed at the time, dat	e end place, and dus	to the cause(s) and man	nner ss stated.	
₩ 0	onel	On the besis of exeminati	on and/or investigation	on, in my opinion,	death occured at the	lime, data and place, an	d dus to the c	ause(s) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	Mu	hu	9	29c. LICENSE NUM	MBER 99	29d. DATE S	IGNED (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF D	EATH (ITEM 27) (Type	Print)	B. P.	THESDA	Mx.	20817
	31. DATE FILEN MOPIN. Por bear 1997	32. REGISTRAR'S SIG	NATURE ROLL		15 708	110-2111	- 12	
		1/1	- Control					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 3 5 6 9 8

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ledical	ı,	MattieTod		throp			th Oh. T-			9	91	1546
aminer	ľ	4a. Facility Name (If not institution Suburbay					10 11	wn, or Location of	Death	4c. County	1	nery
eral	- 1	5. Sociel Security Number 220–16–4969	- 35 ···	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Ya Months Da		Min. (Mont	of Birth h, Dey, Yes	916	9. Birthplac Country Virgi:	ce (State or Foreig
	-	Usuel Residence of Decedent							- , , .	710	11161	
tor	IN	Maryland Montgo	omery	Chevy	Town or Loc Chas	eation					10d	l Inside City Limit 1 ☐ Yes 2X N
Funeral Director	200	10e. Street and Number 3589 Hamlet Place	ce			10f. Zip Coo 20815	e	-	10g. (U.S		het Country	n
unera	nieta	11. Marital Stetus	Armed For		13. V	Vas Decedent Yas, specify (of Hispenic Ori Cuban, Mexican	gin? (Specify Yes o	or No-		e - American k, White, etc	
þ	2	1 ☐ Never Merried 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	led 1 ☐ Yas If Yes, Give Yeer or Da	9	1	☐ Yes 2 🖾	No Specify:				White	
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Be C	וא	17. Father's Neme (First, Middle,	Last)				18. Mothe	er's Name (First, M	iddle, Meid	en <i>Sumam</i>	a)	
To	I	Robert Little				_		Grizzard				h
	1	19a. Informent's Neme/Reletions Edward Lathrop	hip <i>(Type, Print)</i> Husband					er or Rural Route A Chevy Ch				ode)
once.		20e. Method of Disposition	- CD	con	ca of Dispos	ition (Name or etory or other	place)	Dete	20c.	Location -	City or Town	n, Stete
		1 ☑ Buriai 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S		MAIA	-	s Ceme		11/13	Ann	apoli	s, Mai	ryland
- Supplemental		21. Signature of Funerel Sarvica	Licensee		Jos	eph Ga		Sons, In	c. 51	30 WI	Avenu	ue, NW
	+	23a Bart Estado distala a	- O ~	was d the death			n, D.C.					10001
in		23a. Part Esterthe disease, or shock, or heart failule. List	only one ceuse on ee	ch line.	Do not ente	i tha mode of	uying, such es	cardiac or respired	ory errest,		In	pproximete iterval Batween inset and Death
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n/Medical Examiner	5		0 00	1	- I	renca or):	rale				12	2 da
Examiner		Sequentielly list conditions,	Г Ь.		s a consequ	ience of):	10100					, orang
E		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events	. Hy	sex te	nsin	h						ears
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an/Medical			d. A+	rial	+	lutt	er				177	Ionth.
ysicia	1	Pert II. Other significant condition	ns contributing to dea	ath but not resulti	ing in the un	derlying cause	given in Part i.	23b.	Did tobac	co use con	tribute to th	na cause of death
by Physicia		Atrial	septal	de	fect				1 🗆 Yes	205 No	3 Probat	oly 4 ☐ Unknow
llon: To Be Completed by Physicia								24e.	Wes en au performed	topsy	eveile	eutopsy findings able prior to eletion of cause ath?
Con									1 ☐ Yes	2 100	1 🗆 Y	'es 2□ No
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1-1		1 Yes 28 No 27. Manner of Deeth		1	?/Outpetlent	3LI DOA		rsing Home 5				/
ton		1 Avaturel 5 Pendin 2 Accident Investig	M .	, Day Year)	8b. Time of Injury		njury et Vork? ☐ Yes 2☐ I		upe now in	jury occurre	ed .	
Certification:		3 Suicide 6 Could r 4 Homicide determ	not be 28e. Placa o	of Injury - At hom g, etc. (Specify)	e, farm, stre			28f. Locat	on (Street r Town, Str	and Numbe	er or Rural R	loute Number,
0		29e. Certifier 1 Certifyin	g Phyefolan: To the b	est of my knowle	edge, deeth	occurred et the	time, date and	d placa, end due to	the ceuse	(s) end me	nner es stete	ed.
0		(Check only 2 Medical I one)	examiner: On the bes	sis of examinetion	n end/or inve	estigation, In m	y opinion, deel	th occurred et the t	ime, dete e	nd plece, e	nd due to th	e ceuse(s)
edical						29c. Lic	ense number		29d. [ete signed	(Month, Day	y, Year)
Medical		29b. Signeture end title of certifier			1.0							
Medical		29b. Signeture end titla of certifier Nancy	Daven	two	MO	D	415	07	1	1/9	19	7
Medical	3	Nancy 30. Name end eddress of person				(rint)	415	07	1	1/9	19-	7
Medical Certificat	3	Nancy 30. Name end eddress of person	AVENPO		301	(rint)	415 V MEX	07	(E, 1	1/9 MAS	197 H D	7 C 2001



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month MICHAEL. **LAHER** McKIMMIE NOVEMBER 6, 1997 11:50 AM /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNITY PARK, 3724 DAMASCUS ROAD LAYTONSVILLE MONTGOMERY If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yea March 10, 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funerai** Days 1₩ 2□F 216-60-4020 Yrs. 1953 Maryland Director 44 Usuai Rasidanca ol Dacadant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ehow treumatic event, the Medical Examiner must be notified at Director 1 Yas 2 No Maryland Montgomery Poolesville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 238 19626 Whooton Avenue 20837 United States Funeral Was Dacedant of Hispanic Origin? (Specity Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) or items 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☐XNo If Yas, Giva Yaar or Datas: 1 Navar Married 2 N Married 1 ☐ Yas 2 ☐ No Specify: by Specify: 3 ☐ Widowad 4 ☐ Divorced "natural". White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadent's Education lify only highest grade completed) 16b. Kind of Business/Industry (Specify pernit. Peges 1 end 2 should be filed within? Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "geny filury or other treumatic event, or a Mac Bottes. Etamantary/Secondary (0-12) Coliaga (1-4or 5+) Home Remodeler Construction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Albert Lawrence Lauer, Sr. Mae Katherine Stueler 19a. informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Margaret Rose Lauer, 19626 Whooton Ave., Poolesville, MD 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Bunai 2 □ Cramation 3 □ Ramovai Irom Stata
4 □ Donation 5 □ Othar (Specify) Nov 10, Gate of Heaven Cemetery n 5 Othar (Specify) 1997 Silver Spring, MD Funger Service Lie 21. Signal 22. Nama and Addrass of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 pilc iron that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximata intarvat Batween Onsat and Death **Physician** /Medicai Immediata Causa (Finai **ASPHYXTA** ACUTE disaasa or condition rasulting in daath) Examiner Dua to (or as a consequanca of): Examiner DEPRESSION INDEF. The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Due to (or as a consequence of): Physician/Medicai the Dua to (or as a consequence of): 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Wunknown P Q 24b. Wara autopsy lindings available prior to Completed 24a. Was an autopsy peed comptation of causa page 2 s of death? 1 Yas 2 XNo 1 Yas 2 No certificete To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director; to 25. Was casa rafarrad to madical Be 26. Piaca of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Nother (Specify) PARK Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Medical Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 5 Panding invastigation 1 Naturai 1 Yas 2 No NOV 5, 1997 A.M 2 Accidant HOSE FROM EXHAUST 3 Suicida 4 ☐ Homicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) UNITY PARK 29a. Cartifian 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and little of certif 29c. Licansa number 29d. Data signed (Month, Day, Year) D07099 NOVEMBER 7, 1997 n 23a) (Type, Print) 10215 FERNWOOD ROAD, BETHESDA, MD FRANCIS C. MAYLE, M.D.,

32. Registrar's Signatura

DHMH 16 Bay 6/95

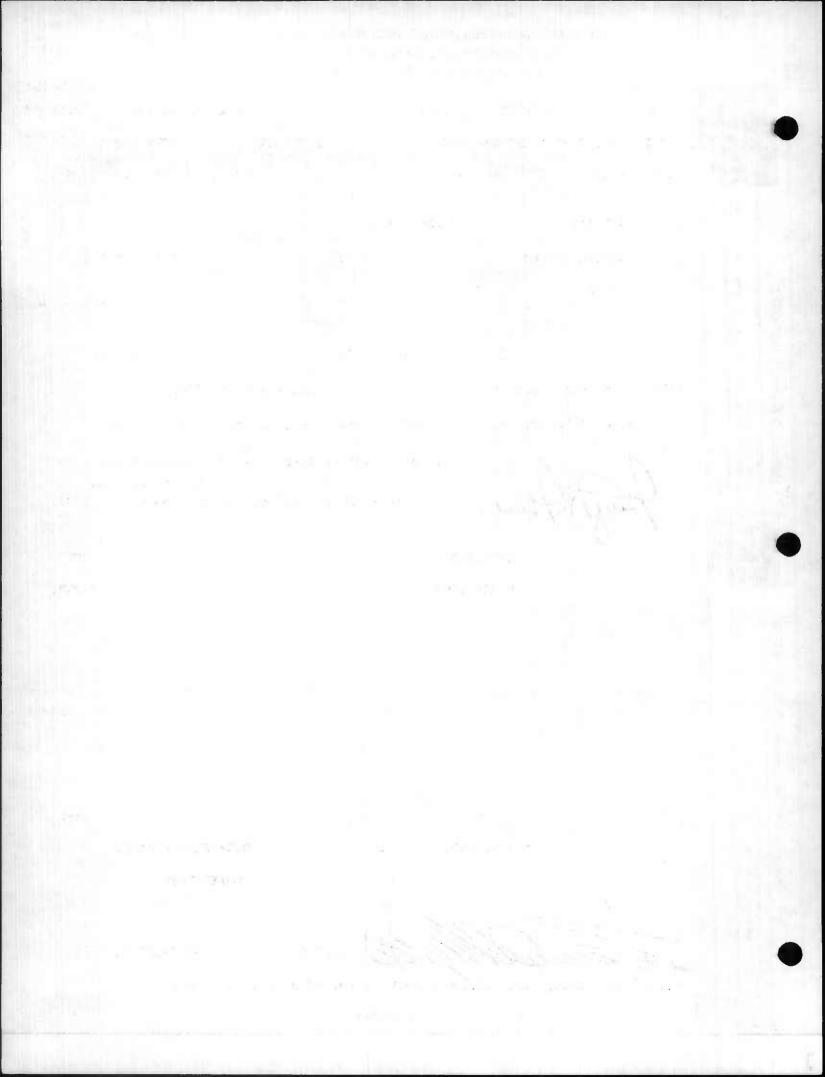
State Registrar

Baltimore, Maryland 21215-0020

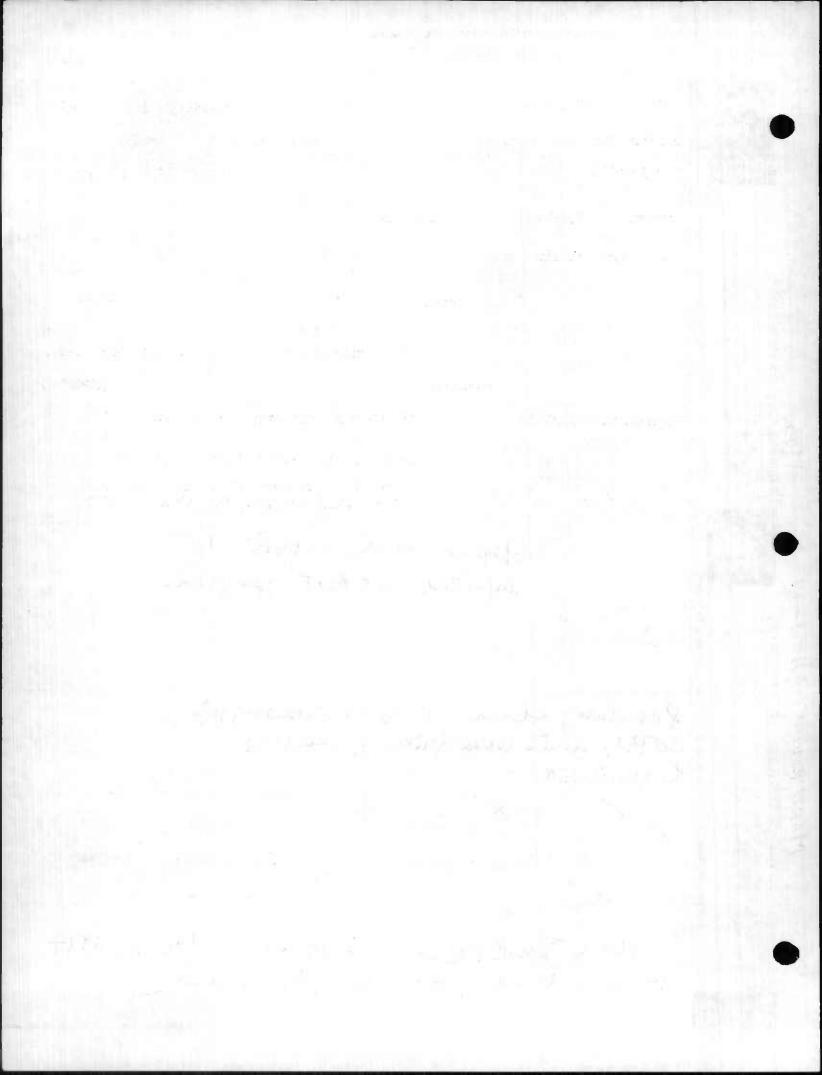
P.O. Box 68760.

Records,

Division of Vital



		Decedent's Name (First, M.	liddle Last)		C	ertificate of	Death		Date of De	Reg. No.		0 T (D
Physici /Medic		ROBERT CHAR							Data of De Month	Day	, 1997	3. Time of Death 5:03 PM
Examin		4a. Facility Name (If not instit			- 7		4b. City, Town			h 4c. (County of Death	
		Harford Memor	-				Havre				Harford	
Funeral Director		5. Social Security Number 188-20-6715 Usual Rasidence of Decaden	6. Sex 1 ★ 2 □		rs. last birthde Yrs.	Months Days		Min. N	Data of Bir (Month, De OVEMD	er 24	1926 Sinth Cour Pen	place (State or Foreigntry) nsylvania
yland		10a. State 10b. Cou		10c. (City, Town or	Location					1	10d. Inside City Limits
the Marylar 28a-f show	Director	Maryland I	Harford		Aberde	en						1 Nes 2 No
vith th		10e. Street and Number				10f. Zip Code				-	en of What Cour	ntry?
eath w	Funeral	635 West Be		nue Decedent Ever in	US 1	21001		2 /Specif	V Vee or No	US	A. Race - Americ	en Indian
iurs after death with the Maryla all, or teems 23a or 28a-f shor Examiner mass be notified at	by	1 ☐ Never Married 2 ☑ I	Armed 1 ☐ Y	d Forces? as 2 □ No W	WII rea	3. Was Decedent of H If Yes, spacify Cub 1 ☐ Yes 2 25 No		uerto Ric	can, etc.)		Black, White,	
n 72 ho natur	Be Completed	15. Dece (Specify only hit Elementery/Secondary (0-1	dent's Education ghest grade complete 2) Cotleg	ed) ge (1-4or 5+)	(Gi	cedent's Usual Occup ve kind of work done b. DO NOT usa retire	during most of	f working			nd of Business/In	
hygian her th	Con	12			Mai	ntenance I					inty Gov	ernment
2 should be filed with and Mantal Hygiana, s marked other that aumatic event, me		17. Father's Name (First, Mid	dle, Last)	(UNKNO)	WN)		18. Mother's	Name (F	irst, Middle	, Malden S		UNKNOWN)
should nd Ma mark imatic	To	19a. informant's Name/Relati	onship (Type, Print)	(OIVITATO)		Illing Address (Street	t and Number of	or Rural F	oute Numb	er. City or		
s 1 and 2 should be filed within Health and Mantal Hygiana. Item 27 is marked other than other traumatic event, tree M		Eugenia O. Ma	nn/Wife			West Bel						
4f O		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramati 4 ☐ Donation 5 ☐ Othe		om State	cametery, c	position (Neme of remetory or other pla Memorial			Date 6/97		cation - City or To	own, Slate
permit. Page Department of Important: If eny Injury or once.		21. Signatura of Funeral Service 23a. Part 1. Enter the disease shock, or heart failure.	a al	Herest		22. Name and Addra Howard K. 1317 Cokes	ass of Facility McComa	s II	I Fun	adon.		
auth cartificate be executed with attending physician and for use as the burial-transit	an/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Due to	(or as a cons	equence of):	ot s	Zew	gre	ne		
the death y the atte	ysick	Part II. Other significant cond	ditions contributing to	o death but not re	esulting In tha	underlying cause give	ven in Part I.		23b. Dld	tobacco u	use contribute to	the cause of death
Physician: Tha law requires that the daath carli r this cartificate has been signed by tha attanding tral director, paga 2 should be datached for usa a	Completed by Physician/M	COPD, C	z edor	oud,	risch	home o	Cardin	MU	24a. Was	an autops	av	ere autopsy findings aitable prior to
Tha law ate has b paga 2 si	omple	Currenter	STA		J		0		10	Yes 2	of	mpletion of cause death?
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Physic this ca ral dire	2	1 Yes	-		☐ ER/Outpat	ient 3L DUA		1			Other (Specif	y)
or Attending Physician: aftar death. Director: Aftar this cartific in by the funeral director,	Certification:	- Carried Control In .	nding (A estigation	ate of Injury fonth, Dey Year)	28b. Time Injury	M 1□	ryat rk?]Yes 2 □ No		f. Describe			10-11
i Date	Certif	4 ☐ Homicide. det		iliding, etc. (Spec		street, factory, office		201	City or To			al Route Number,
he Hospl in 24 hou he Funer plataly fii	edical	29a, Certifier (Check only one) 1 Carti	cal Examiner: On the	the best of my kr e basis of examinanner stated.	nowledge, de nation and/or	eth occurred at the tin investigation, in my o	me, date end p opinion, death	iace, and	due to the at the time,	cause(s) e date and p	end manner as s place, and due to	teted. o the ceuse(s)
To t To t	2	29b. Signatura and title of cer	Jun.	Gu		29c. Licens	se number	+		29d. Date	signed (Month,	Dey, Year)
0+1		30. Name and address of pers	on who completed c	ause of deeth (It	em 23a) (Typ	Print)	, Ma	ry	lan	L		
		31. Date tiled (Month, Dev. Ye	ar) 32	. Redistrar's Bio	nature A	4 4	1	0				



State of Maryland / Department of Health and Mental Hygiene

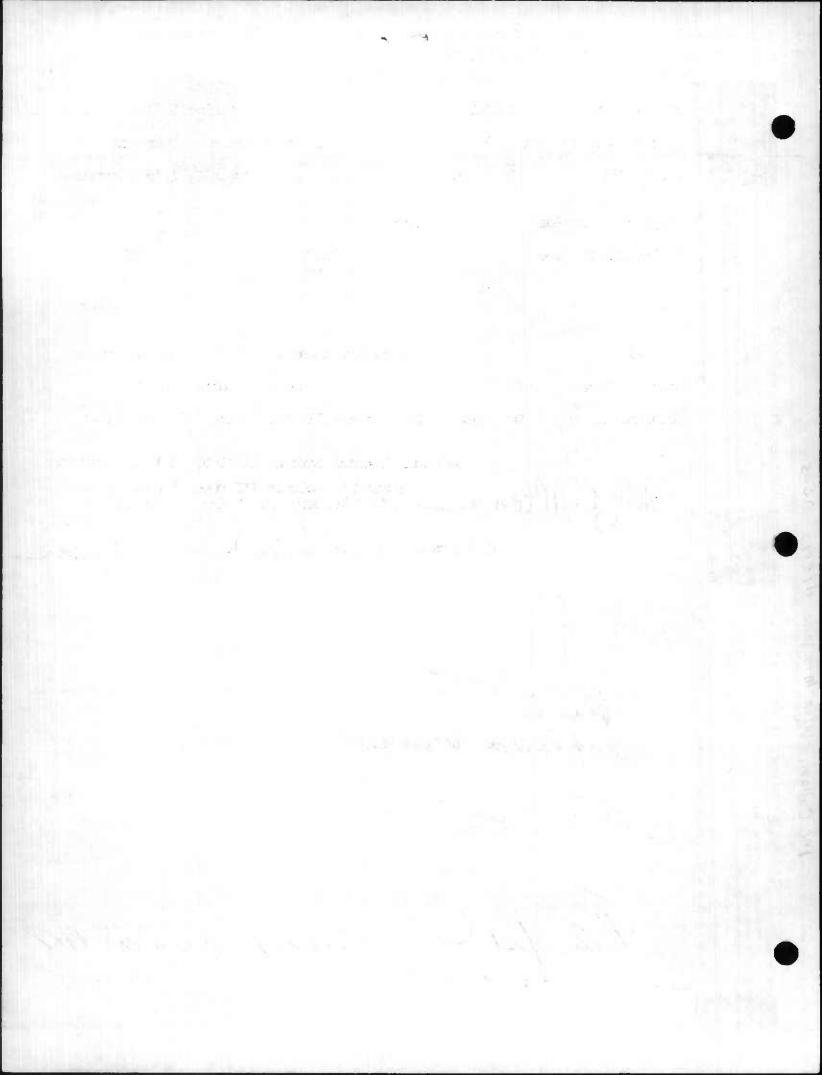
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Vear **EVELYN** MARGE MCCALLUM 5:25 A.M. November 8, 1997 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 20XF Months Yrs. Director 216-24-3242 82 Aug. 18, 1915 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exactors must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3843-B Memory Lane 21009 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department Manager d 2 should be filed with end Mental Hygie 7 is marked other ti U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) John Thomas Duff Lula Naomi Lynch 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth er Important: If Item 27 is any injury or other trau Jennifer K. Brown - Daughter 4791 Norrisville Rd., White Hall, MD 21161 20b. Place of Disposition (Name of cametery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State ty Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 11-11-97 Bel Air, Maryland 0638 HS 0838 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Bud Due to (or as a consequence of): Physician/Medicai the Due to (or as a consequence of): Part II. Other significa og to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy n of cause 2 LNo certificate Division of Vital Be 25. Was case referred to meeta 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1□ Yes 2⊞ No 1 ☐ Inpetfent 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Defural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 D Hominida 8 To the Hospital of within 24 hours at To the Funeral D completely filled in Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier (Check only one) 29b. Signatur (an 10 State Registrar

MARJORIE

Evelyn

Callami



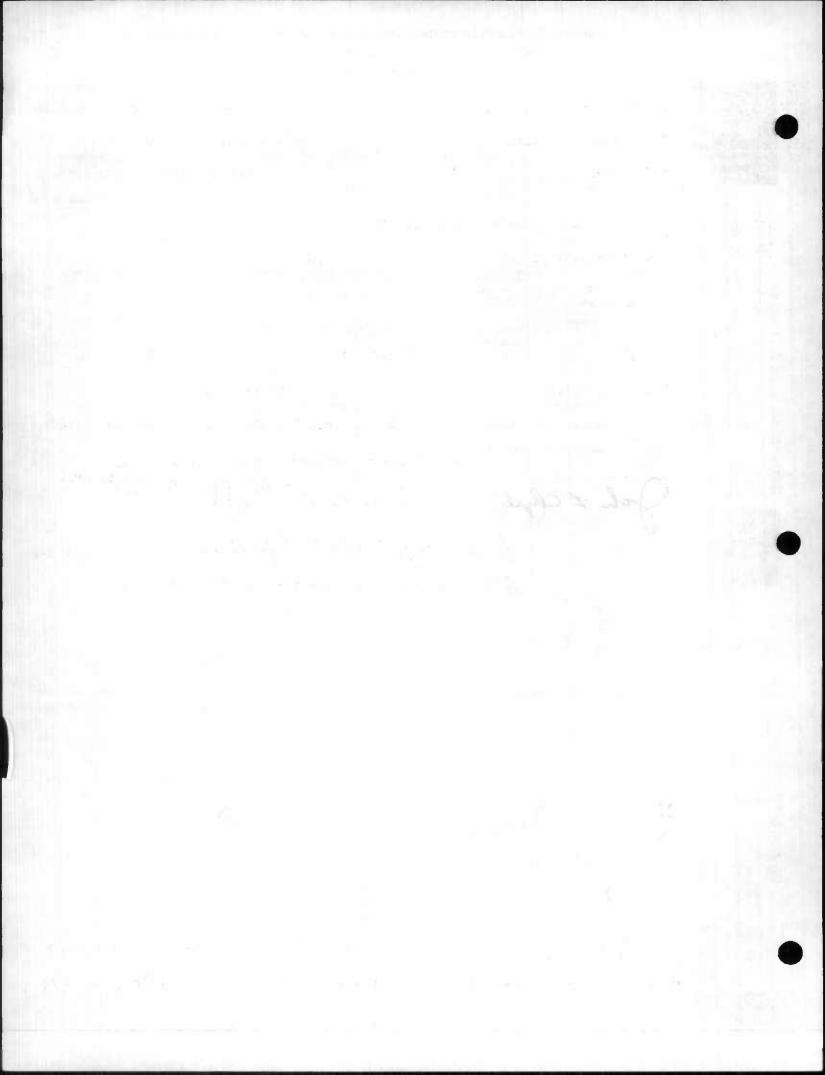
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al', or frems 23a or Examiner must be	Completed by Funeral Director	1 ☐ Never Merried 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forcas' 1 ☐ Yas 2 ☑ If Yes, Give Year or Dates:				2 No	Specify:	to Rican, etc.)	Speci	ack, Whita, a	nite
no mental hygiene. marked other than "natural", imatic event, tre Med cal Ext	ted	15. Decedent's E	Education		16a. Decede	ent's Usi	al Occur	ation	4	18b. Kind of B	Business/Ind	ustry
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Is marked of	To	George	John		Eder			ANNA	N	IARY	VO	GEL
e ma		19a. Informant's Name/Reletionship	(Type, Print)		19b. Mailing	Addras	s (Street	and Number or Fi	ural Route Numl	per, City or Town	, Stata, Zip	Coda)
em 27 l		John B. Chest	er / Son			sam	e as	#10				
Item Officer		20a. Method of Disposition			lace of Dispos	ition (Ne	oma of	ce)	Data	20c. Location	- City or Tov	vn, Stata
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Department of neetin and mental hygiente. Important: if Item 27 is marked other than "natural; any Injury or other traumatic event, the Ned cal Engage.		21. Signeture of Funarai Sarvice Lice)				ss of Facility Z Funer				rar y rand
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State of Maryland / Department of H	lealth and Mental Hygiene 97 3570

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To		Robert McCol	lum					Cor	inn	e Simps	son			
traum	1	19e. Informant's Name/Relations	ship (Type, Pnint)		19b. Mailir	ng Address (S	treet en	d Number	or Run	al Route Numb	er, City or	Town,	State, Zip	Code)
17		Roy Marshall	(husba					a Str	eet	, Colle	ege P	ark	, MD	20740
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If Under 1 Year Months Deys

10f. Zip Coda

1 ☐ Yes 2 No

Auto Mechanic

20740

State of Maryland / Depa

irtment of Health and	Mental Hygiene	1	331
tificate of Death	Reg. No.		

2. Date of Death

Month

	1. Decedeni's Name (First,	Middle, Last)
Physician /Medicai	Richard	Kei
Examiner	4a. Facility Nama (If not ins	titution, giva s

RICHARD KEITH MASTERS

Richard Keith Masters 4a. Facility Nama (If not institution, giva street and number)

49TH AVENUE

NOV. 4b. City, Town, or Location of Death COLLEGE PARK

1997 1445 PM 4c. County of Death

PRINCE GEORGES

Funeral Director

28a-f show

6

238 death

items

"naturel", or

other

permit. Pages 1 end 2. Department of Health el Important: if item 27 is eny injury or other travonce.

Physician

/Medical Examiner

the

attending for use es

6

signed b

ate hes b

Hospital or Attanding Physician: 24 hours after deeth. Funeral Director: After this certifica stely filled in by the funeral director, I

To the Hospital within 24 hours a To the Funeral Completely filled

10

that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

filed within 7. Hygiene.

is 1 end 2 should be fill I Health end Mental H tem 27 is marked out

Director

Funeral

by

Completed

Be

10

Examiner

Physiclan/Medical

þ

Completed

Be

Certification: To

Medical

traumatic event, the Medical Examiner must be notified at

the Maryland

efter

Baltimore, Maryland 21215-0020

Usual Residence of Decedent Maryland Prince George's 10e. Street and Number

5. Social Security Number

213-44-2752

9528

10b. County 10c. City, Town or Location

X M 2□ F

If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 11, 1944

9. Birthplace (Steta or Foraign Washington, D.C.

College Park

7. Aga (In yrs. last birthdey)

53 Yrs.

10d. Inside City Limits YOK Yes 2 No

3. Time of Death

9528 49th Avenue

11. Marital Status XXNevar Marriad 2 Married 12. Was Decedent Ever in U,S. Armed Forces? XIXYas 2 □ No If Yes, Give If Yes, Give Year or Dates: 1965–1967 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.)

14. Race - Amarlcen Indian, Black, White, etc.

White

United States

3 Widowed 4 Divorced

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Specify:

10g. Citizen of What Country?

12 17. Fether's Name (First, Middle, Last)

Masters

18. Mother's Name (First, Middle, Melden Sumeme)

Alpheous

19a. informent's Name/Relationship (Type, Print)

Edith 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

Rilev

Self Employed

Kenneth M. Masters (Brother)

P.O. Box 433 Lewes, Delaware 20c. Location - City or Town, State

20a. Method of Disposition XX Burlat 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Maryland Veterans Cemetery 11/7/1997 Crownsville, Md.

Donation 5 Other (Specify)

Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part1. Entar tha disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

housale Disease

Immediata Causa (Final diseese or condition resulting In deeth)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or es e consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown

24e. Wes an autopsy performed?

24b. Wera autopsy findings aveileble prior to completion of causa of daath? Yas 2 No

Approximete intarval Between Onset and Deeth

25. Was cese referred to medical examiner? XX Yes 2 No

27. Manner of Deeth

1 Natural
2 Accident

3 Suicide

4 Homloide

Hospital: 28a. Date of Injury (Month, Dey Year) 5 Pending Investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes

Other: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

X Yas

26. Piece of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

29a. Certain (Charant

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29h. Sin nd title of certifier

29c. License number O.C.M.E

29d. Date signed (Month, Dey, Year) NOV. 5, 1997

of person who completed ceuse of death (Item 23a) (Type, Print)

31. Data filed (Month, Dey, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

NOV12

6 Could not be

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Director

Funeral

P P

Completed

2

Examiner

Physician/Medical

à

Completed

Be

10

Certification:

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

Month 1997

4:00P.M.

1 X Yes 2 ☐ No

Approximate intervel Betw Onset and Death

years

years

4 weeks

Funeral Director

r 28a-f show r than "natural", or items 23a or the Medical Examiner must be r hours after

d 2 should be filed within 7. Ih and Mental Hygiene. 7 is marked other than "ru Hygiene. permit. Pages 1 and 2 st Department of Health and Important: if then 27 is n any injury or other traun odds.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

that the death certificate be executed physician and s the burial-trans for use es signed by the e peen page 2 hes certificate Attending Physician: funeral director, After Hospital or Attending 24 hours effer deeth. Funeral Director: Afte filled in by To the Hospital within 24 hours a To the Funeral Completely filled

P.O. Box 68760.

Division of Vital

November 6, James Joseph Mc Cabe 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Carriage Hill - Bethesda Bethesda Montgomery 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 9. Birthplaca (State or Foreign Country) New York 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 1₩ M 2□ F Yrs Sept. 83 15,1914 059-03-3286 Usuel Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5128 Scarsdale Road 20816-2321 U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes: 1 Nevar Marriad 2 Merried 1 Yas 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) training officer State Department 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Melden Surnama) Anne O'Brien James McCabe 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sara T. McCabe/wife 5128 Scarsdale Rd., Bethesda, MD. 20816-2321 20b. Place of Disposition (Nema of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Steta Dete 1 ☐ Burlet 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Nov. 10,97 SIlver Spring, Md. 22. Nema and Address of Fecility DeVol Funeral Home 21. Signature of Euperal Service License 2222 Wisconsin Ave., N.W. Wash. D.C. 20007 Park. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in deeth) congestive heart failure Due to (or as a consequence of): malnutrition Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) urosepsis Dua to (or as e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2€ No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was case refarred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 26b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 1 □ Yes 2 □ No 2 Accident

5 Pending Investigation 6 Could not be

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tittle of certifier.

29c. License number D32033 29d. Dete signed (Month, Day, Year) Nov. 7,1997

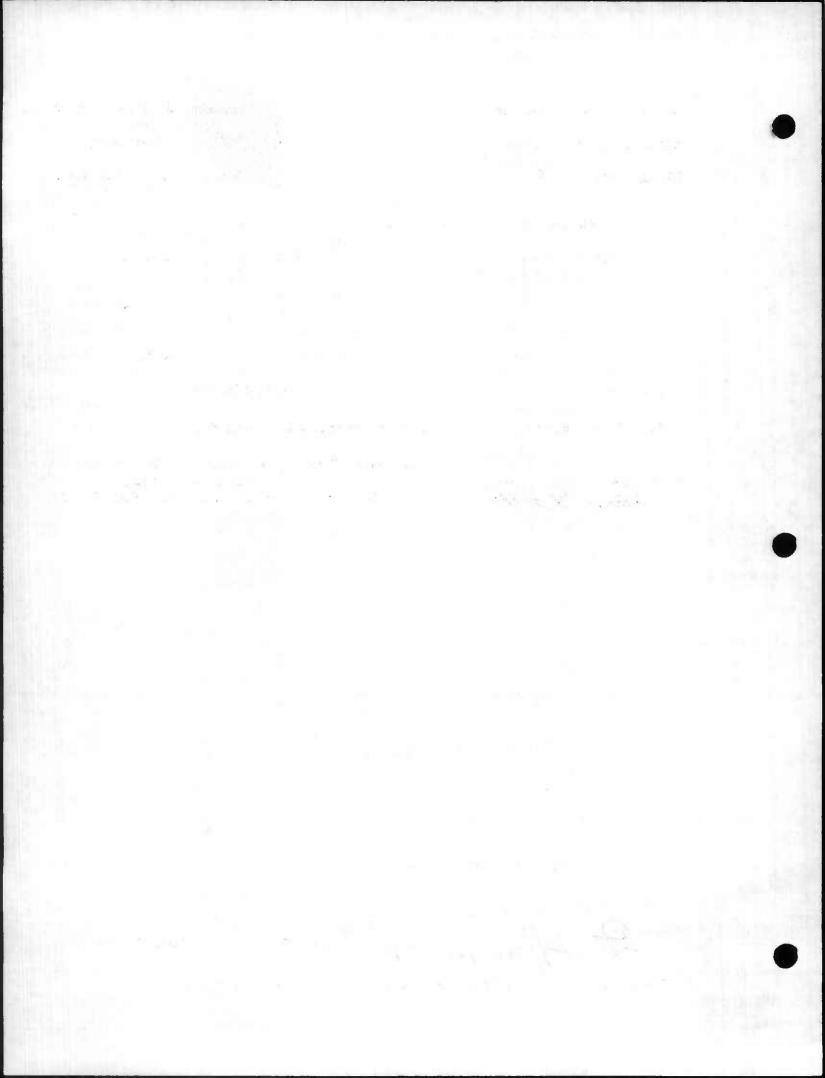
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Peter G. Hamm, M.D., 5454 Wisconsin Ave., Chevy Chase, Md. 20815 31. Dete filed (Month, Day, Year) 4 1997

State Registrar

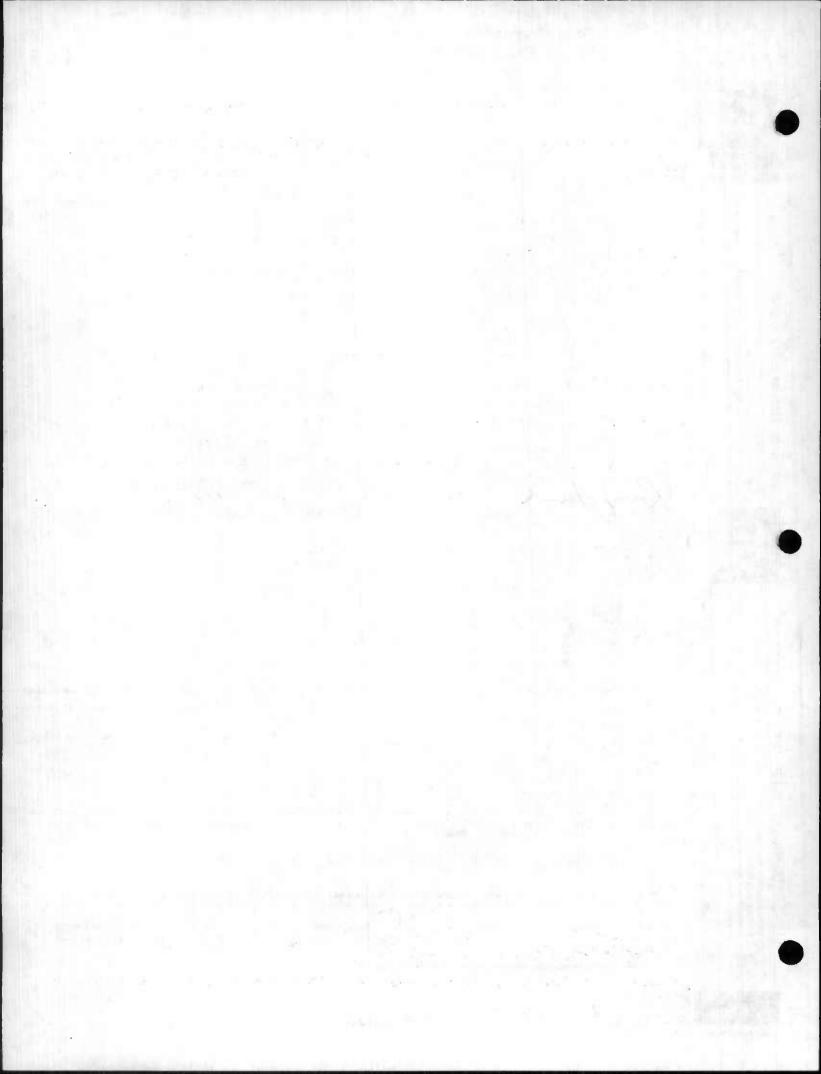


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State of Maryland / Department of Health and Mental Hygiene 0.7 25706

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S. Source Security Numbers 6. Saw 7. Apr (by year as brothety) 1. Horizon 1. Apr (c) 1	aminer								th 4c. Cour	nty of Deeth	
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The other's Name (First, Micotile, Last) The other Donahue 1se, Melmar's Name (First, Micotile, Maiden Summen) Mildred James 1se, Melmar's Name (First, Micotile, Maiden Summen) Mildred James 1se, Melmar's Name (First, Micotile, Maiden Summen) Mildred James 1se, Melmar's Name (First, Micotile, Maiden Summen) Mildred James 1se, Melmar's Name (First, Micotile, Maiden Summen) Mildred James 1se, Mailing Address (Silvert and Number or Paul Rouse Number, City or Town, State, Zp Code) 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition 13412 Bonnie Dale Dr., North Potomac, MD 20878 2co. Membed of Disposition Color Town, State And Deale Dr., North Potomac, MD 20878 2co. Membed of Disposition Color Town, State And Deale Dr., North Potomac, MD 20878 2co. Membed of Disposition Color Town State And Deale Dr., North Potomac, MD 20878 2co. Membed of Disposition Color Town State And Deale Dr., North Potomac, MD 20878 2co. Membed of Disposition Color Town State And Deale Dr., North Potomac, MD 20878 2co. Membed of Disposition Color Town State And Deale Dr., North Potomac, Color Town State And Deale Dr., North Potomac, Color Dr., North Potomac, Color Dr., North Potomac, Color Dr., Nor	<u>a</u>	13412 Bonnie Dal	e Drive			2087	8		United	State	es
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The God re Donahue The God re The The God re The The God re The God re The God re The The God re The The God re The The God re The The The God re The The The The The The The The The Th	mo	Elamantary/Secondary (0-12)		+)					Own	n Home	
Theodore Donahue Theodore Donahue Theodore Donahue Theodore Donahue Theodore Ponahue Theodore	17. Fether's Nama (First, Middle, Les)				18. Mothar's N	ama (First, Middle				
196. Mailing Addrass (Sinest and Number or Rual Route Number, City or Town, State, Zp Code) William Donahum McLaren/Son	0	Theodore Donahue					Mildr	ed James	3		
20s. Method of Disposition District 2 (Schemation 3 Flamoval from State			Type, Print)	19b	. Mailing	Addrass (Street	and Number or I	Rural Route Numb	er, City or Tow	n, State, Zij	o Code)
20. All Mond of Disposition Bear Disposition Disposition (Name of or order place) Nov. 13, 1999 20. Constitute Disposition (Name of order place) Nov. 13, 1999 20. Constitute Disposition (Name of order place) Disposition (Name		William Donahue M	cLaren/Son	13	412	Bonnie	Dale Dr.	, North	Potomac	. MD	20878
4 Donasion S Clother (Specify) 21. Signature of Furnaria Sarvice Licenses MO0198 22. Signature of Furnaria Sarvice Licenses MO0198 23. Part Enter 196 disease, or complications that coursed the death. Do not annur the mode of dyrig, such a received or respiratory arrest. Approximate financials Cause (Final resulting in death) Because Institute List conditions, as consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death willing in death) 24a. Was an autopsy performed? 24a. Was an autopsy performed? 25c. Was coas raterrad to medical washington by the complete of cause of death in the cau			30	20b. Placa of cemater	Disposi	tion (Name of	ce) Nov 1				
22. Signature of Funaral Sarvice Licensea MO0198 ROBERT A. Pumphrey Funeral Home/Rockville, Ind 300 West Montgomera 20550-2805 Approximate and Season of Capity and Season of Complication that caused the death. Do not amar the mode of dyrig, such as cardiac or respiratory a rest. Approximate Constitution and the constitution of the consequence of: Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 225. Was geas referred to medical resulting in death) Last Due to (or as a consequence of): 246. Was an autopsy performed? 247. Was an autopsy performed? 248. Was an autopsy performed? 249. Was an autopsy performed? 240. Was autopsy indirection of data. 257. Was geas referred to medical language and the consequence of the con		4 Donation 5 DOther (Speci	64)	Monto	0 7 0 2	T Cmama		T	Bethes	da. M	[arvland
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24a. Was an autopsy finding available prior to completion of cause of death? 25. Was cesa referred to medical axaminer? 25. Was cesa referred to medical axaminer? 26. Was cesa referred to medical axaminer? 27. Manner of Death 1	sicia	Pert ti. Other significant conditions of	ontributing to death bu	t not rasulting in	tha und	arlylng ceusa giv	van in Part I:	23b. Did	tobacco use c	ontribute to	o the cause of deat
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29b. Signatura and titla of certifier 29c. Licansa numbar D07094 November 12, 1997 30. Nama and addrass of person who compliated causa of death (Itam 210 Hyps Proul Frances C. Mayle, M.D., 10215 Fernwood Road #301, Bethesda, Maryland 20817-1106	edical ((Check only 2 XMedicat Exam	niner: On the basis of a	axamination and	daath o	ccurrad at tha tir stigation, in my o	na, data and place pinion, daath occ	e, and due to the curred at tha tima,	ceuse(s) and n data and place	nanner as s , and dua to	teted. o tha causa(s)
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	State		, M.D., 10	215 Fer	100		#301, Be	thesda,	Marylar	nd 208	317-1106

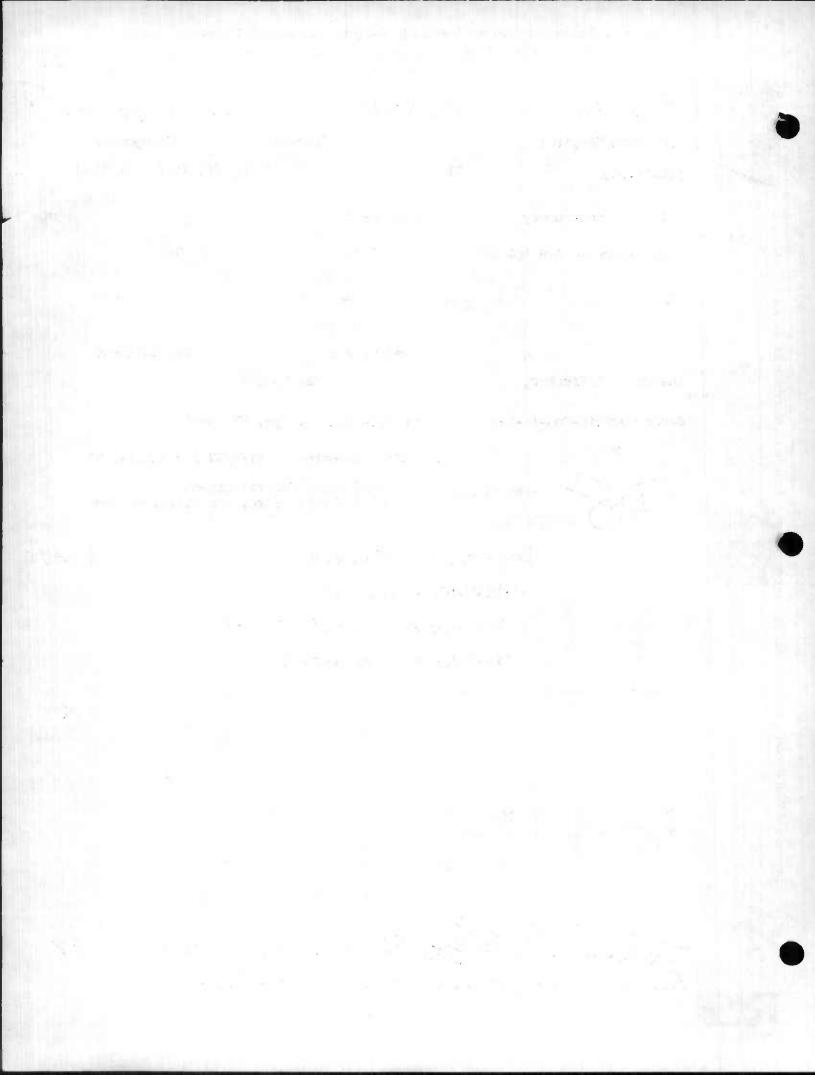


State of Maryland / Department of Health and Mental Hygiene 97 35707

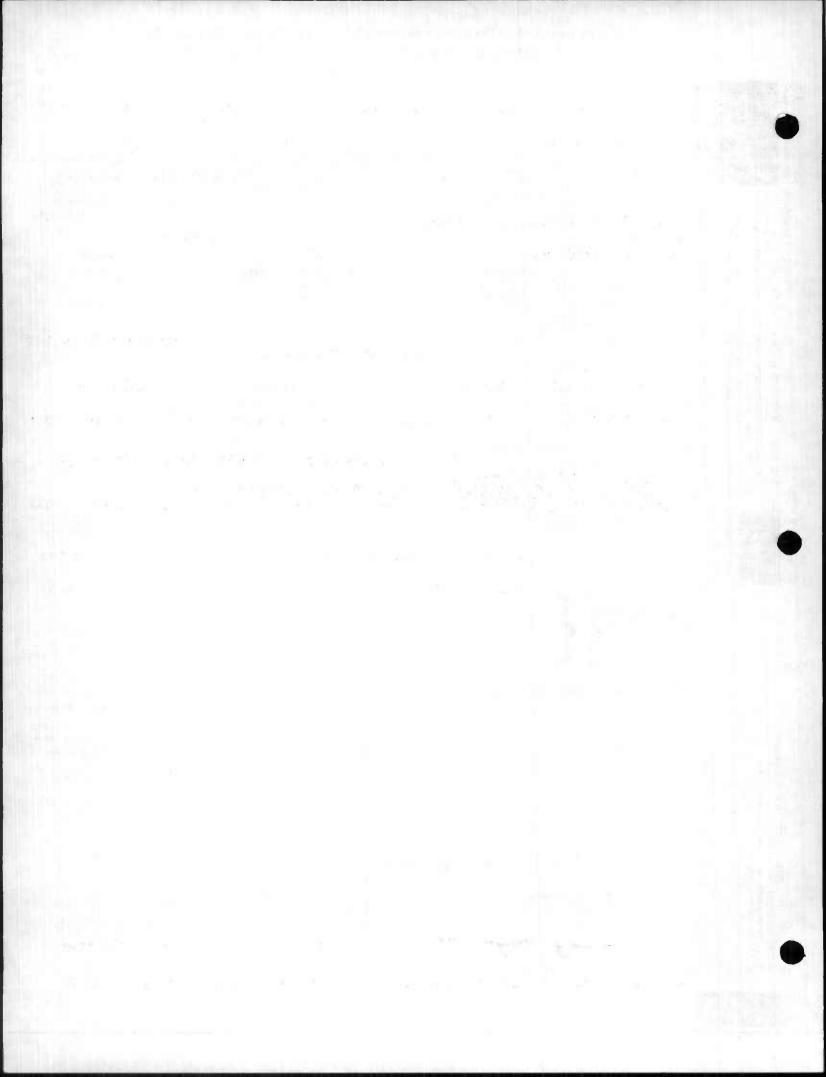
					Cer	tificate o	f Death		Reg. No.	,	0101
Physician	_	1. Decedent's Neme (First, Middle, Last)				1-		2. Dete of De		Year_	3. Tima of Deeth
' /Medical	ı.	ALLAN	A	M	ERI	NE	(NOV	3	97	0017A
Examiner		le. Fecility Nama (If not institution, giva					4b. City, Town, or	Location of Deet		362	
		Suburban Hospita				William Addition	Bethesda			gomer	У
Funeral Director		5. Social Security Number 578-36-2006 Usuel Residence of Decedent	M 2□ F	91	ast birthday) _ Yrs.	If Under 1 Yas Months Dey			th , Y1906	9. Birthpl Coun Eng	ace (Stete or Foreign and
š m	-	10a. State 10b. County		10c. City	, Town or Loc	ation				10	Od. Inside City Limits
1 p		MD Montgome	ery		Chevy	Chase					1 ☐ Yes 2 No
r items 23a or 28a-fe creat must be northed Funeral Director		10e. Street and Number 5600 Wisconsin Ave	Apt 18F			10f. Zip Code 20815			10g. Citizen of USA	What Coun	try?
ò À		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Dacadant & Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Yaar or Datas:	lo		/as Dacedant of Yes, specify Cu ☐ Yes 2 2 N	f Hispanic Origin? (uban, Maxican, Pue o <i>Specify:</i>	Specify Yas or Norto Rican, etc.)		ca - America ck, White, e y: Whit	elc.
d other than "nature event, tre Wed call Be Completed		15. Decadent's Educ (Specify only highest grade Elementery/Secondery (0-12)	College (1-4or 5	+)	(Give I life. D		ne during most of wi red)	orking	16b. Kind of B		
Co me		17. Fathar's Name (First, Middla, Last)	4		Dus.	inessmaı		oma (First, Middle	Own Bu		S
atic ever To Be		Isadore Goffenbe	erg				Rae Mer		, maideit Surriai	ila)	
s marked other than sumatic event, the Market To Be Comp		19e. Informant's Neme/Reletionship (Ty)	oe. Print)		19b Meilin	a Address (Stre	et and Number or F	Rural Route Numb	er City or Town	State Zin	Code)
27 is treu		James Gurfein-Son-					h Rd. Rye			, Olele, Zip	0000)
or other treumatic	2	20e. Mathod of Disposition		20b. Pi	eca of Dispos	ition (Neme of	_	Dete	20c. Location	- City or To	wn, Stete
		1 ☐ Buriel 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emovel from Stata			ort Cre	- /	11/5/97	Alexand	ria,	VA
important: any injury once.	1	21. Signature of Funeral Service Licanse	е	1	22.	Name end Add	rass of Facility	1			The second of
any ir		· AC	-Dan Sim	ons			agel Fune			·m 00	050
	+	23a. Pert1. Enter the disease, or complishock, or hear tallure. List only on	cetions thet caused	the deeth.	. Do not ente	J91 ROCI	kville Pi	Ke, Kock	ville,	MD 20	
sician	1	shock, or heal talluror List only on	e ceuse on eech lin	10.						į	Approximete toterval Between Onset and Deeth
edicai		Immediete Ceuse (Finel	CIEDE.	h a a		1					CAAVO
niner	1	disease or condition resulting In deeth)	CERE		es e consequ		119			- 1	8 DAYS
Je J	1									1	
iel-trensit Examiner	1	Sequentially list conditions,	0/1/10	Due to (or	es e consequ	RES7					
EX EX		Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury						(101)			
for use es the buriel-trensit		thet initieted events resulting in deeth) Lest	1	Dua to (or	es e consequ	enca of):	ARCTI	0,0		1	
Med			HIF	> R	= PL	ACE A	MENT			1	
or us		d			- 1 -/	105/	10/0/				
De S	F	Part II. Other significant conditions con	ributing to death bu	it not resul	lting in the un	derlying cause	given in Pert t.	23b. Dld	tobacco use co	ntribute to	the cause of death?
detect detect	•							10	Yes 2□ No	3 Prob	ebly Munknown
E 2 2							0.0	24e. Wes	an autopsy	24b. We	re autopsy findings
page 2 should								pont	Jilliou I	con	npletion of cause leeth?
page 2								10	Yes 2 No	1□	Yes 2 No
rector, par Be Co		25. Wes case referred to medical					26. Plece of De	eth (Check only	one)		
P P		exeminer?	ospitel: 150 Inpatie	nt 2 E	ER/Outpetient	3□ DOA	other:	Home 5□ Resi		ner (Specify)
	1	27. Manner ot Deeth 1 Neturel 5 Pending 2 Accident Investigation	28e. Dete of Injur (Month, Dey	Year)	28b. Time of Injury	28c. In W	jury et ork? □ Yes 2 □ No	28d. Describe	how injury occur	red	
ai Director: After tied in by the funeral		3 Suicide 6 Could not be determined	28e. Plece of Inju- building, etc	iry - At hor :. (Specify)	ma, farm, stre	et, factory, offic	0	28f. Location (City or To	Street and Numi wn, Stete)	ber or Rura	Route Number,
To the Funeral Director Completely filled in by Medical Certif		29e. Certifier 1 Certifying Phys (Check only 2 Medical Examin	er: On the basis of	exeminetic	rladge, death on end/or inve	occurred et the	time, dete and plea	ea, end due to the curred et the time.	ceuse(s) end madate end plece.	anner as st	eted. The ceuse(s)
Med	-	onej	and manner sta	ted.	1						
2 0	1	29b. Signatura and this of summer	0 11	1/1	- 1	Lica:	nse number		29d. Date signe	u (Month, L	yay, 1997)
		A mel	ene	y	11	Do	709	9	NOV	6	7+
	3	FRANCIS C	npleted cause of de	eth (Item	23e) (Type, E	Print)	, A.	2.	4		
		TRANCIS C /	THYLE 1	0215	1-ER	NWOO)	apr &	WETH	SDA		

State Registrar

31. Dete tiled (Month, Day, Yaer)



						Certificate		-	Reg. No.	7 3	0,00
	Physic	ian	1. Decedent's Neme (First, Middle, Darlene		M	cholelei		2. Dete of De Month	Dey	Yeer	3. Time of Death
	/Medi Examii		4a. Fecility Neme (If not Institution,	Ann give street end number		ichalski	4b. City, Town,	Novembe or Location of Death			1:50 PM
	CXAIIIII	ilei	4520 Boastfield				Olney			gomery	
	Funeral Director		348-26-9918	5. Sex 1 □ M 2 ☑ F	ge (In yrs. lest bi	rthdey) If Under 1 Yrs. Months I		Hrs. 8. Dete of Bird Min. (Month, De August 2	th y, Year) 6, 1934	9. Birthplece Country) Illi	e (State or Foreign
700	***	1	Usuel Residenca of Decedent 10a. Stete 10b. County		10c. City, Tow	n or Location				10d.	Inside City Limits
Mak	r sho	to	Maryland Monto	jomery	Olney						1 ☐ Yes 2 No
the d	7.28s	Director	10e. Street end Number	JOHNEL J	o inoj	10f. Zip C	ode		10g. Citizen of V	Whet Country's	?
3	238		4520 Boastfield	Lane			20832		United	d State	es
5-0020	Then, it indicates after desire with the marylar liber. If then "natural, or thems 23s or 28s-4 show the "Mad call Examinet mant be notified at	by Funeral	11. Merital Stetus 1 □ Never Merried 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Wes Deceden Armed Forces d 1 Yes 2 If Yes, Give Year or Detes:		13. Was Deceder If Yes, specify		? (Specify Yes or No uerto Rican, etc.)	14. Raci Bled Specify	e - American ck, White, etc.	
2-0-2	retur	ted	15. Decadent's (Specify only highest	Education	16e	Decedent's Usuel ((Give kind of work life. DO NOT use	occupation	unding	16b. Kind of Bu	siness/Indus	try
Maryland 21215-0020	jene.	Completed	Elementery/Secondery (0-12)	College (1-4or	5+)	iiie. Do NOT use	Managemen	nt	Health		titute of
	d d d	Be	17. Fether's Neme (First, Middle, Li	,	200			Name (First, Middle,		etherta	220
aryla	h and Mental	To	D. Frank 1 19e. Informent's Neme/Reletionshi			Adattina Address /	Hel				
	trau		David Michalski			-		Drive, Wo			,
altimore,	t then y		20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Spe	□Removel from Stete	20b. Plece o camete	f Disposition (Name ry, cremetory or othe peake Cre	of r plece)	Dete 11-13-97	20c. Location - Beltsvi	City or Town,	Stete
			21. Signeture of Fundami Separate L		Chesa	22. Name end	Address of Fecility			ile, n	arytana
n š	Deper Impor		23a. Pert1. Enter the diseese, or c shock, or heert feilure. List or	omplications that cause	ed the deeth. Do line.	933 Gis	Avenue,	vices, P.A Silver Spredictory of	oring, M	Ap	proximete ervel Between
- 1	hysician /Medical xaminer		Immediate Ceuse (Finel disease or condition resulting In deeth)	. Maligna	ant Pleu	ral Effus	ion				months
		ē		D		consequence of):				2	
uted	d ansit	Examine	Convention by lies and distance	b. Breast	Carcino	IIId.				3	years
Ç,	an an		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying		540 10 (0. 00 0	0011004201100 01).					
OX 00/00, certificate be executed	ding se s	/Medical	Cause (Diseese or injury that initiated events resulting in deeth) Last	c	Due to (or es e	consequenca of):					
death cert	otter u	Physician/M	Dort II Other standiland and dis-					000 014			
) E	to the	hys	Pert II. Other significant condition	s contributing to death i	out not resulting I	n the underlying cau	se given in Peri I.		lobacco usa cor Yes 2⊠ No		s causs of death? ly 4 ☐ Unknow
s thet	pe det	by P							168 230140	30,110000	iy 4 Olikilow
OI VICAL RECORDS, P. Physician: The law requires thet	2 8 2	Completed						24a. Wes perio	en eutopsy med?	eveilel	eutopsy findings ble prior to etion of cause th?
L eff	- 0	E O						1 🗆 '	Yes 2 No	1 🗆 Y	es 2 No
Sen:		Be	25. Wes case referred to medical examiner?				26. Plece of	Deeth (Check only o	ne)		
Physician:	0 0	2	1 ☐ Yes 2 🛣 No		ent 2□ER/Ou			ng Home 5 ☑ Resk			
Du	Te de	Certification:	27. Menner of Deeth 1 🖾 Neturel 5 🗌 Pending 2 🗀 Accident investiga 3 🗆 Suicide 6 🖨 Could no	t he	ay Year)	М	Injury et Work? 1 Yes 2 No		now injury occurr		
ital or A	24 hours after death Funeral Director; Jetaly filled in by the f		4 ☐ Homicide determin	and Zoe. Pleca of in	ic. (Specify)	rm, street, fectory, o	TICE	City or Tov	Street end Numb vn, Stete)	er or mural mo	xute Number,
The Hospital	hin 24 hou the Fune npletaly fi	ledicai	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of end manner s	of examinetion an	d/or Investigetion, in	my opinion, deeth o	leca, end due to the occurred et the time,	cause(s) end me date end plece, o	nner as stete and due to the	d. ceuse(s)
		Σ	29b. Signeture end title of cartifier	1 24 +	,00		cense number		29d. Date signed		
1	5			d. made			D23630		November	r 10,	1997
			30. Name and address of person with Frank J. Mayo, M	I.D., 16220	Frederi		#213, Gai	thersburg	, Maryla	and 20	0877
	Sta Registr		31. Dete filed (Month, Day, Year) NOV 1 2	1997 32. Regist	rer's Signeture	- Randelle					

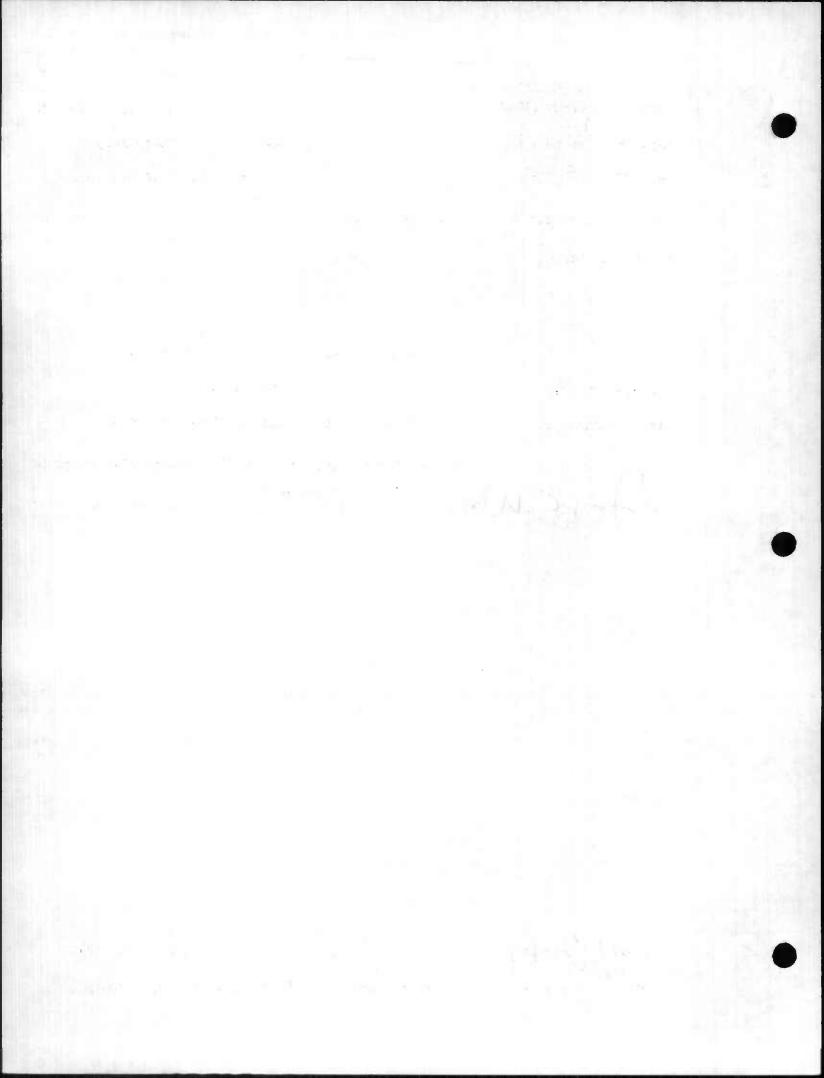


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ysician	_	1. Decedent's Name (First, Mi Samuel Jose		Mille	r						2. Dete of D Month	Day	Year	3. Time of I	
Medical	١ -	Samuel Jose 4e. Fecility Neme (If not institu							- (4	b. City. Town, or L	11	5 th 40 Court	97_	8:05	AM
aminer	r				moer)				-	_	LOCATION OF DOO		y of Death		
		Potomac Mano: 5. Sociel Security Number	6. Se		7. Age (In yr.	last hir	thday	If Under 1 Y	ear	Potomac If Under 24 Hrs.	8 Date of B		gomery		- Earnian
eral ector		225-10-5353		M 2□F	83		Yrs.	Months D		Hours Min.	8. Deta of B (Month, D May 1	(ay, Year)	New Y	laca (Stata or try) 'ork	roraign
	- 1-	Usuel Residence of Decedant											11.00		
3		10a. Stata 10b. Cou	,		10c. C	ity, Tow	n or Loc	ation					1:	0d. Inside Cit	
cto	3	Florida Cha	rlott	e	Po	rt C	har.	lotte						12 Yas	2 No
Sire Sire		10a. Street and Number						10f. Zip Cod	da			10g. Citizan of	What Coun	try?	
1 10	8	3170 Fulton S	treet	:				3395	2			U.S.A.			
any injury or other traumetic event, the Medical Examinations must be notified at some. To Be Completed by Funeral Director		11. Marital Status 1 □ Nevar Married 2 ☑ N 3 □ Widowed 4 □ Divoro	larried	12. Was Dece Armed Fo 1 ☐ Yes If Yas, Giv Yeer or D	2 🔯 No	U,S.	lf.	as Decedant Yes, specify (Cuba	spanic Origin? (Sin, Mexican, Puerle Specify:	pecify Yes or No Rican, etc.)		ce - Americack, Whita,	atc.	
ted		15. Deced	iant's Edu	cation	atas.	16a.	Deceda	ant's Usual Oc	ccupa	ition	kina	16b. Kind of E	Businass/Inc	lustry	
Completed	1	Elemantary/Secondary (0-1)	1	College (1	1-4or 5+)	F		o NOT usa re	0.00	uring most of wor	King	Food s	ervice		
Ü	5	17. Fethar's Nema (First, Midd	lle, Last)							18. Mothar's Nan	na (First, Middle	a. Maidan Surne	me)		
To Be		Joseph Mil	1er							Minnie	Dubrow	d milesonie se se			
-	-	19a. informant's Name/Ralatic		roe. Print)		19b	. Mailine	Addrass (St	reet s	and Number or Ru	ral Routa Num	her City or Town	Stata Zin	Code)	
		Marc A. Mille		,						. Bethes				0000)	
	-	20a. Mathod of Disposition	,		20b.	Place of	Dispos	ition (Nema o	of		Data	20c. Location		wn, Stata	
		1 Bunel 2 Cremetic		lemovel from				etory or other			7107				
	-	4 Donation 5 Other 21. Signature of Funeral Servi			Me	trop		tan Cre			v./'9/	Alexand	ria,	Virgin	.1a
n ni	-1	23a. Part I. Enter the disease shock or heart failure. Immediate Causa (Final disease or condition rasulting in death)	or compli list only or		aused tha dad ach lina.		not anta	22 Wisc rtha moda of	COT dylng	sin Ave. g, such es cardiec	N.W. or raspiratory	Washing arrast,	ton, D	.C. 20 Approximata Interval Betw Onset and D	veen
ě					Dua to	(or as a c	consequ	ance of):					1		
VMedical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest	{))				ence of):							
Physician/M	-	Part II. Other eignificant cond	itions con	tributing to de	eath but not re	suiting In	the un	deriving cause	a nive	in In Part I	23h Die	I tobacco use c	ontribute to	the cause of	d death?
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Registrar

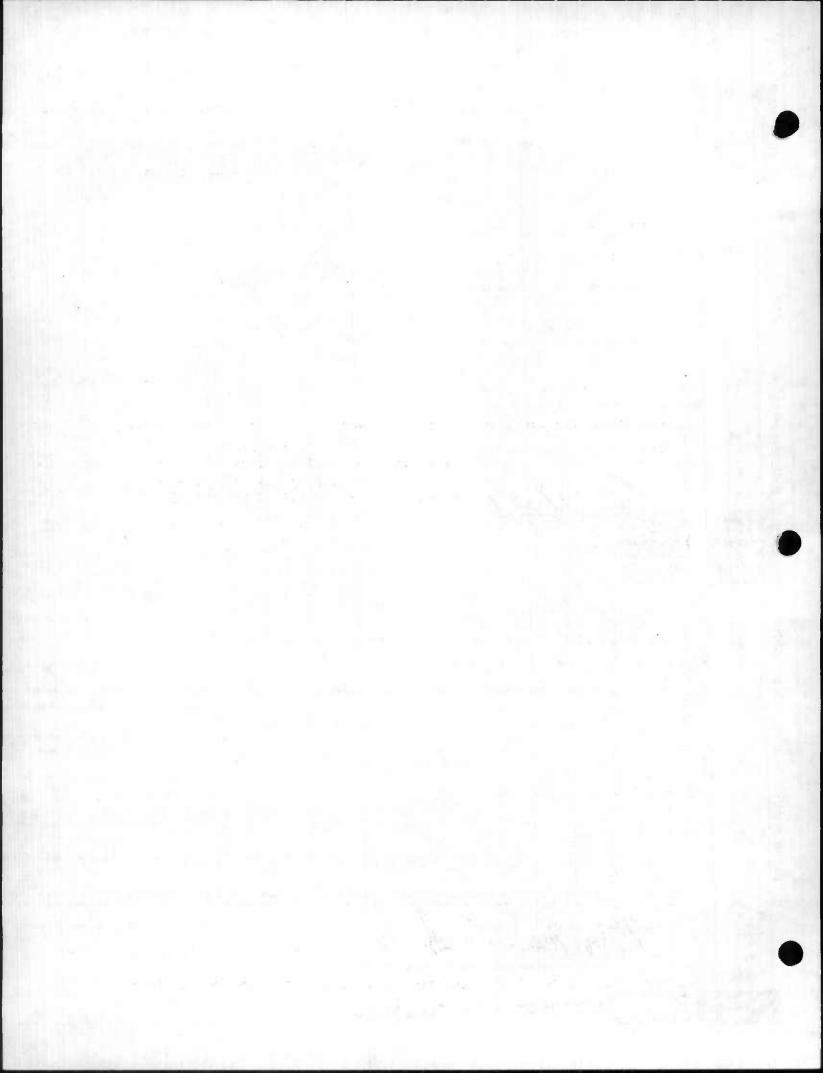
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Kenneth Mc Connel 2:50PM 10 4a Facility Neme (If not Institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Silver Spring

If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth

Month, Dey,

Jan. 7, Holy Cross Hospital Montgomery 5. Sociel Security Number 9. Birthplece (State or Foreign Country) New York 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F Months Yrs. 082-18-3263 73 Usual Residence of Deceden 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3602 Isbell Street 20906 USA 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Yeer or Detes: 1943-46 Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation 18b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Government/ Navy Dept. 4 Chemical Engineer 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) John M. McConnell Mildred E. Lybolt 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Name/Reletionship (Type, Print) Eileen M. McConnell 3602 Isbell Street, Silver Spring, MD (wife) 20906 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Removel trom State Gate of Heaven Cemetery 11/13/97 Silver Spring, MD

22. Name and Address of Facility Francis J. Collins Funeral 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or been tellure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final Due to (or es e consequence of): diseese or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence ot): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to completion of cause of death? 24e. Wes an eutopsy mi rend 1 Yes 2 ₩ 1 ☐ Yes 2 ☐ No arkingm com 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation Iniun 1 Yes 2 No

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Physician

/Medical

Examiner

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7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinat must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural:' or item any injury or other traument.

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Baltimore, Maryland 21215-0020

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29b. Signeture en of certifie

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

20400 Kisen 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

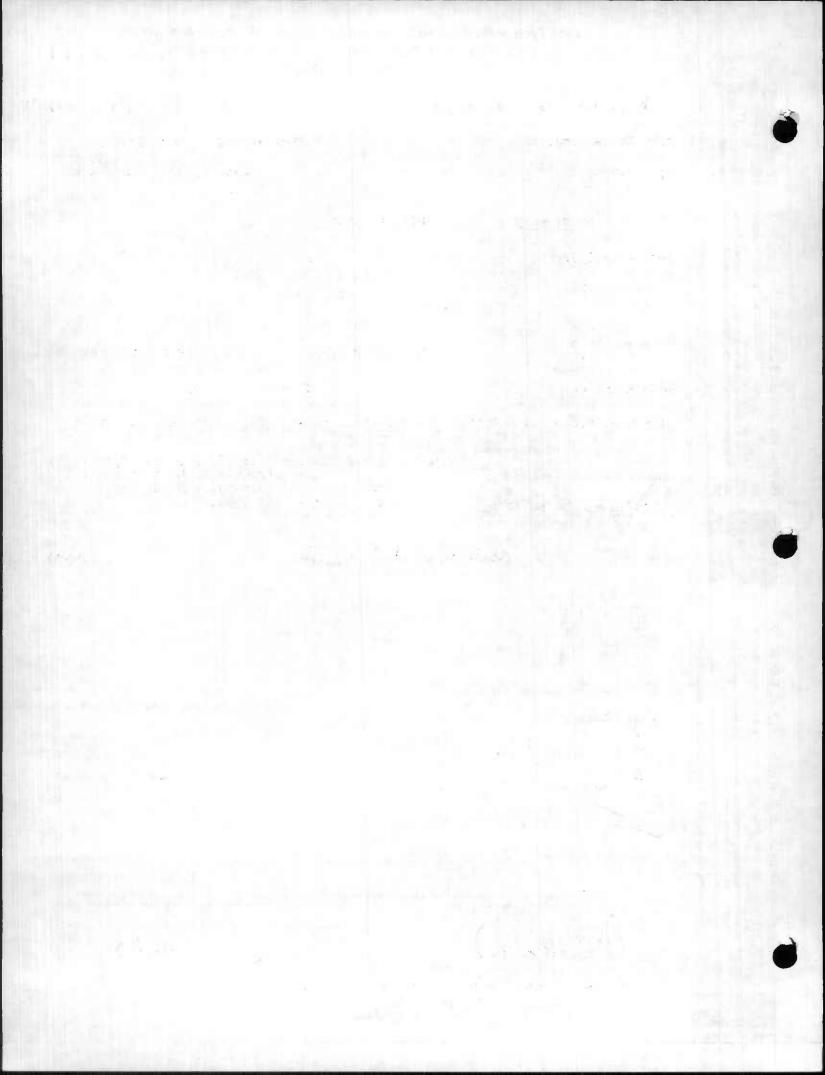
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32. Registrar's Signeture

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death Month **Physician** November 10, 1997 Robert Lee Money, Sr. 12:00 PM /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20410 Shore Harbour Drive, Apt.J Germantown Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (Stefe or Foreign Country) 1 1 M 2 □ F Months Yrs. 579-50-3901 58 Feb. 3, 1939 Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20410 Shore Harbour Drive, Apt.J 20874 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. ☐ Yes 2 XNo f Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 Divorcad Year or Dates: White Be Completed 15. Decedent's Education (Specify only highest grede completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Fireman Fire & Rescue 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Aubrey Burton Money Emma Carter 2 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 Betty L. Money / Wife 20410 Shore Harbour Drive, Apt. J, Germantown, MD 20b. Place of Disposition (Name of cometery, cremetery or other place) Nov. 13, 20a. Method of Disposition 20c. Locetion - City or Town, State 1 ₺ Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Home/Rockville, Inc., 300 W. Montgomery Ave. 21. Signature of Funerel Service Licansee M00348 Rockville, Maryland 20850-2805 Fulla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximate Intervai Between Onset end Death Immediete Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residenca 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Manner of Death Dete of Injury (Month, Dey Yeer) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause death (Item 23a) (Type, Print) ene 32. Registrar's Signature State who Davidson

The law requires that the death certificate be execu Records, P.O. Box 68760, Division of Vital or Attanding Physician: **Funeral**

Director

28a-1 show

r than "natural", or items 23a or 28a-f show the Wed cal Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter to Department of Healith and Mental Hyglene. Important: If Item 27 is merked other than "natural", or ite any injury or other traumatic event, the Mod Call Engine

Physician

/Medical Examiner

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page 2 105

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Baltimore, Maryland 21215-0020

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To the Hospital or Attendi within 24 hours after death To the Funeral Director: A C

DHMH 16 Rev 6/95

Registrar

Judge Parlies

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. T f th Month **Physician** Mildred Detrick Monello November 5, 1997 0035AM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ROCKVIIIE
If Under 1 Yaar | If Undar 24 Hrs. | 8. [
Months Days Hours Min. SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Hours 1 M 200 57 Yrs. 211-30-5317 June 3, 1940 Pennsylvania Usual Residence of Decedeni 10a. Slata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 16808 Briardale Road Funeral 20855 United States 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ② No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Navar Married 2 Married 1 ☐ Yas 2 🛣 No Specify: þ 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) National Housing College (1-4or 5+) Redevelopment Director of Conventions 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be P Ralph Detrick Charlotte Weimer 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Monello/Husband 16808 Briardale Road, Rockville, Maryland 20855 20b. Place of Disposition (Name of comatery, crematory or other place)
St. Peter's Catholic
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Nov. 8, 1997 Libertytown, Maryland 21. Signature of Feberal Service Du 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 M00803 Rockville, Maryland 300 West Montgomery Avenue and 20850-2805 • M00803 Rockville, Maryland 20850-2

23a. Part1. Enter the disaasa, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death Metastatic Non small cell lung Cancer 9 months Immediate Cause (Final disease or condition resulting in death) Examiner Sequantially list conditions, if any, leading to Immadiata cause. Enter Underlying Ceuse (Disease or Injury Ihal initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medicai Dua to (or as a consaguanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□ Yes 2BNo 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 hopatient 2 ER/Outpatlent 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 333224 hours NOVEMBER 03, 1997 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Br #303 Rockvelle Mo 20852 RAM TRAHAD MO 20 W Edmonston

32. Registrar's Signature

Julia Savidson Bandall

State Registrar

Funeral

Director

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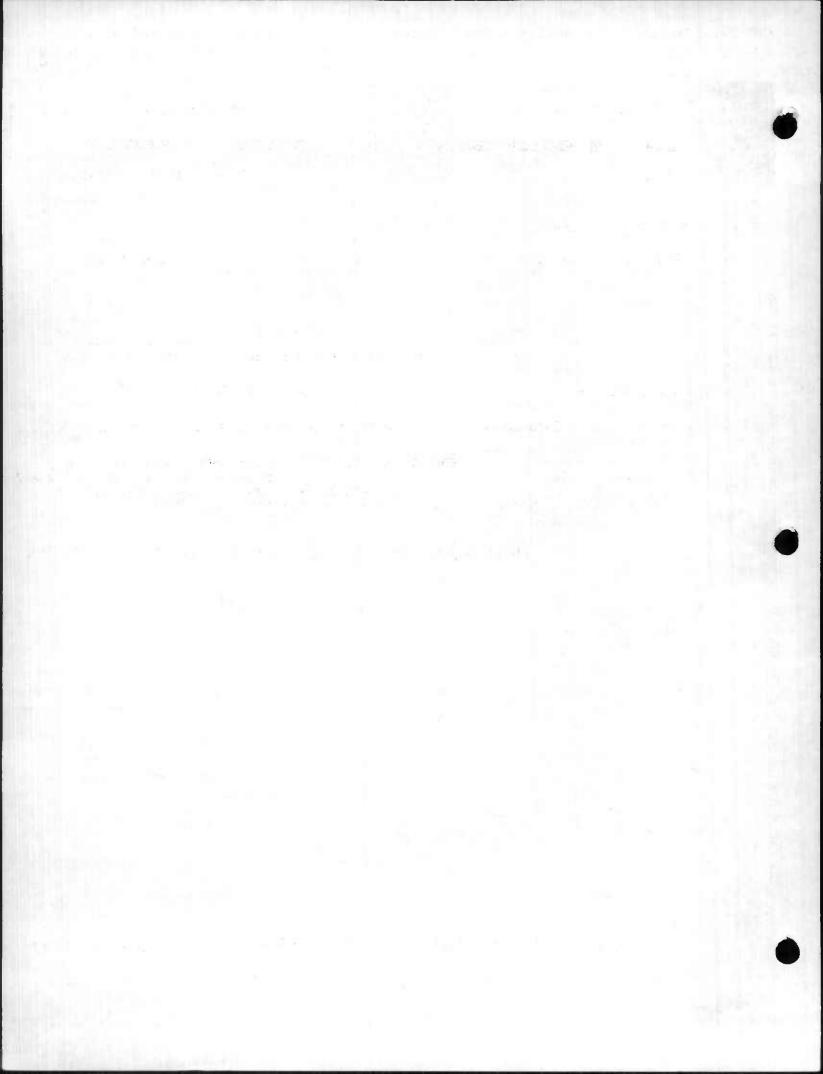
P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0020

Biller



State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month November 11 4:42pm Margaret Adelaide Norris /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death Examiner Ia Plata

If Under 1 Year | If Under 24 Hrs.

Months Deys Hours Min. Physicians Memorial Hospital Charles 4 Hrs. 8. Date of Birth
Min. M. M. M. M. Devry Year) 1918 Scientify MD 7. Age (In yrs. lest birthdey) 5. Social Security Number **Funeral** 1 M 20 F Yrs. Director 217-46-9323 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits MD Charles Cobb Island 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 18785 Wicomico River Dr. 20625 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - Amarican Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Lewis Emmanuel Jenkins Adelaide Howe Jenkins 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) John M. Norris/Son 9080 Balsam Run BelAlton MD 20611 20b. Place of Disposition (Neme of cemetery, cremetory or other place)
Holy Ghost Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlei 2 □ Cremation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify) 11/15/97 Issue, MD 21. Signature of Funeral Service Licansea AREMART ECHOLS FUNERAL HOME, INC. MO0945 P.O. Box 567 LaPlata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Ceusa (Final disease or condition resulting in death) a. GANGRENE OF INTESTENE

Due to (or es e consequence of): FEW DAYS HERNIA STRANGULATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequenca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PULMONARY EMBOLESM 1 Yes 2 No 3 Probably 4 Unknown þ SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? ADULT RESPIRATORY DISTRESS SYNDROME 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner?

1 Yes 2 No Be 26. Plece of Death (Check only one) Hospitei: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 27. Manner of Deeth 26a. Date of injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury at Work? 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signatura and titla of certifiar mangantla 29c. License number 29d. Date signad (Month, Day, Year) D - 26064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Dey, Year) NOV 1 4 1997

Vidyasagar Anmangandla Rt. 5 & Golden Beach Road, P.O. Box 282, Charlotte Hall, Maryland 20622 32. Registrar's Signature Fire Davelson Randall

the Meryland

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Menyian Depertment of Health end Mental Hygiene.
Important: If team 27 is marked other than "natural", or itema 23a or 28a-f show sny injury or other traumatic avant, the Medical Examine must be not only injury or other traumatic avant, the Medical Examine must be not only

Physician /Medical

Examiner

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attending physician for use as the burie

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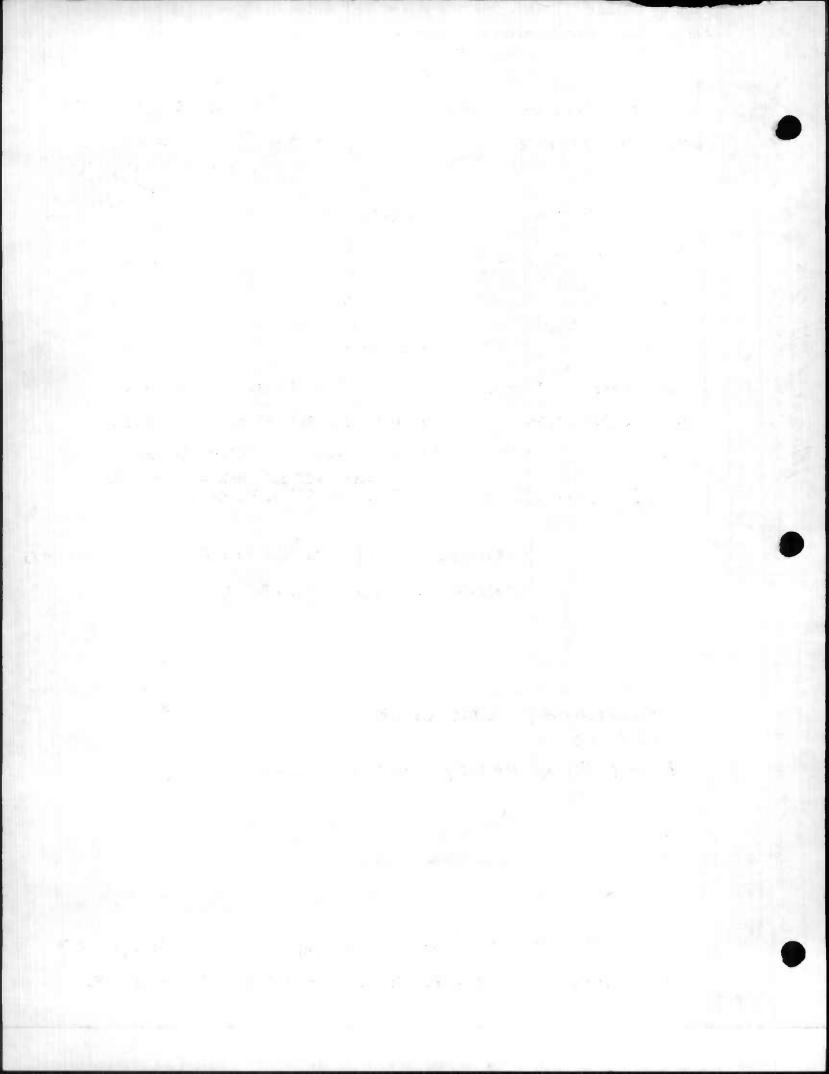
To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Diractor: After this certific completely filled in by the funeral director.

Records, P.O. Box 68760.

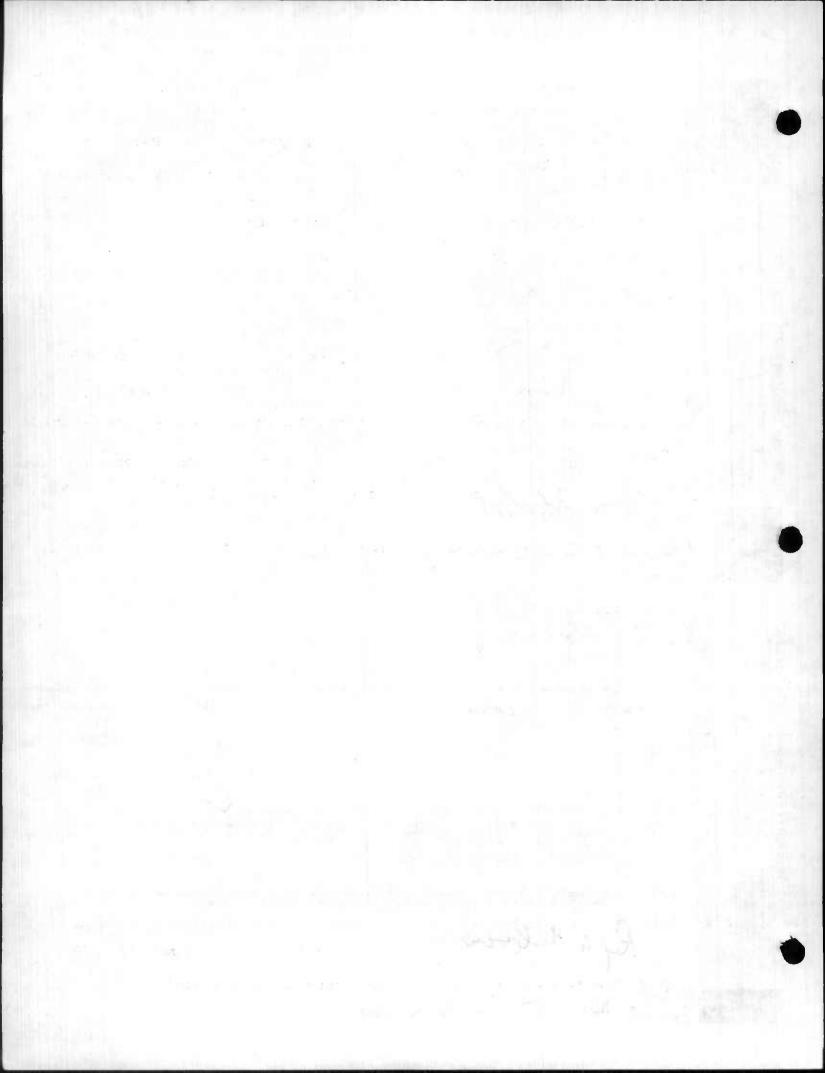
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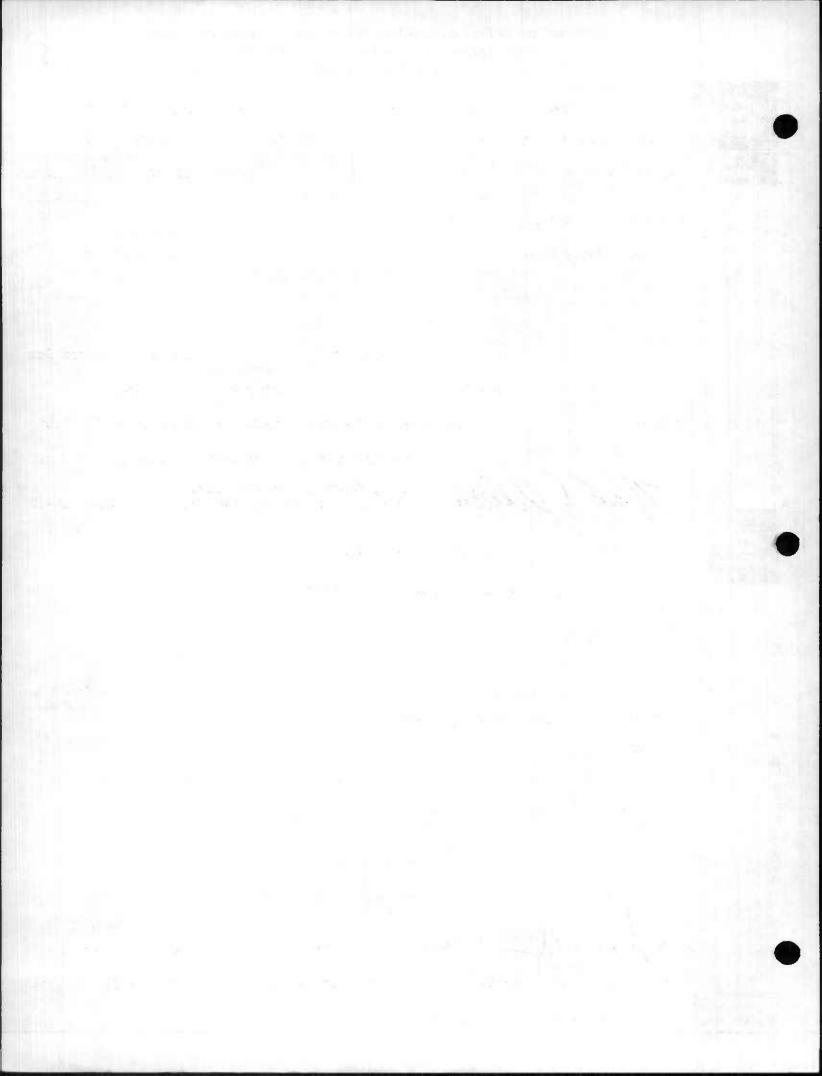
State of Maryland / Department of Health and Mental Hygiene

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al', or items 23a or 28a-f show Examiner must be notified at	tor	Maryland Mc	ntgomery				Chevy Cha	ase		10	Yes 2⊠No
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or l	by F	1 ☐ Navar Merried 2 ☐ Married	If Yes, Give)		☐ Yes 2X No			Specif		
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7 Is marks traumatic		19e. Informent's Name/Reletio	nshlp (Type, Print)		19b. Meilln	g Address (Street	t end Number or Ru	irel Routa Number	, City or Town,	State, Zip Code)	
SI F		Antonina Rond	ini/ Daught	er	2804	East Wes	st Highwa	-			
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	n 3 DRemovel from S	tate 20b. i	Place of Dispos cemetery, crem	sition (Name of netory or other ple	00)Nov. 13	, 1997	20c. Location -	- City or Town, Sta	te
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Delli	edicai Ce	Check only 2 Medica	ing Physician: To the b	is of examine	wledge, deeth tion end/or Invi	occurred at the tin	me, dete end piece	, and due to the ca	use(s) end me	enner as stated. and due to the ceu	18 e (s)
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State of Maryland / Department of Health and Mental Hygiene 97 35716

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/Medi		Nina Anne			Pierre		Novembe			25 AM
Examir	ner	4e. Facility Name (If not institution, give street end number)					r Location of Daeth	The second of the second		
74 DE		Carriage Hill Nursing Home Bethesda Montgomery								
Funerai Director		5. Social Security Number 109-14-3875 6. Sax 1							State or Foraign , Austri	
pue *		Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Li								side City Limits
Mary!	by Funeral Director								1 ☐ Yas 2]X) No	
128. DCH		10e. Street and Number			10f. Zip Coda			10g. Citizen of What Country?		
3a o		5215 West Cedar Lane			20814			United States		
n 72 hours after death with the Maryland "natural", or Hems 23s or 28s-f show solical Experience must be netified at		I. Marital Status 1		S. 13. Was Decedant of Hispanic Origin? (Spe If Yas, specify Cuben, Maxican, Puarto f			(Specify Yas or No arto Ricen, atc.)	ify Yas or No- cen, atc.) 14. Race - American Indian, Black, White, etc. Specify: White		
tural		15. Decedant's Ed		16a C	6a. Decedant's Usual Occupation			16h Kind of Bu	Kind of Business/Industry	
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2 should be and Mental is marked o aumatic ave	To	Emil Hutter			Mare		garet		Ruhe	
and and is m		19a. Informant's Name/Relationship (Type, Pnint)	19b. I	Meiling Address (Stre	at and Number or I	Rural Routa Numbe	er, City or Town,	Stata, Zip Coda,	
EZNE	-	Andrew Pierre	(son)		0 Charles			2		20007
permit. Pages 1 ar Depertment of Hee important: if itam: any injury or othe once.		I Duniai ZAN Claimation 3 Dramoval from State			f Disposition (Nema of ry, cramatory or other place) Sapeake Crematory 11-		Date 11-10-97	20c. Location - City or Town, Stata Beltsville, Maryland		
by the death certificete be executed by the attanding physician and burnal-transit certificate as the burnal-transit certificate by the certificat	Completed by Physician/Medical Examiner	Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a Part Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onsat and Death Immediate Causa (Fine) disease or condition rasulting in death) Myocardial Infarction Due to (or as a consequence of): Atherosclerotic Heart Disease Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown								
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The law ta has	E O						10	res 2 No	of death?	2 No
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificata his complately filled in by the funeral director, page	edical Co	29a. Cartifler (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end mannar as stated. 2 Medical Examinar: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.								
vithin To the compl	Me	29b. Signature and title of certifler	29c. Licansa number D35579		1	29d. Data signed (Month, Day, Year) November 9, 1997				
Sta Registr	te	30. Nema and address of parson who completed ceuse of daath (Itam 23a) (Type, Print) Susan Miller, M.D., Spence Center, 2 Wisconsin Circle, Chevy Chase, Maryland 20815 31. Data filed (Month, Day, Yaar) NOV10 1997 Julia Davidson Fundase								



State of Maryland / Department of Health and Mental Hygiene 9 /

PAUL E. PACK Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Paul Edward Pack 6, 1997 NOV. 11:50 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□ F 64 Yrs. 1933 Tennessee Director 234-46-5628 Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Directo Maryland Frederick Frederick 10e. Straat and Number 10f. Zip Code 10g. Citizen of What Country? 6 21701 United States items 23a 103 Providence Court death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - American Indian, o filed within 72 hours after de Il Hygiena. other than "natural", or item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify by 3 Wildowad 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wil Department of Health and Marial Hygiens Important: If fem 27 is marked other tha eny fulury or other traumatic event, the J 2010.8. Courier Package Service 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pearl Caldwell Harlie Pack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (daughter) 713 Bay Springs Drive, Sumter, SC 29154 Sheri Prushan 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cramation 3 ☐ Removal from State Chesapeake Crematory 11-10-97 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility
Rapp Funeral Services, P.A. 21. Signature of Funeral Service Ligenses 933 Gist Avenue, Silver Spring, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final Atherosclorunz ardiovuscular direce disease or condition resulting in death) Examiner Physician/Medical Examiner physician and s the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 | Probably 1 should be det Records, þ Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? Parhal 1 TYes 2 □ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

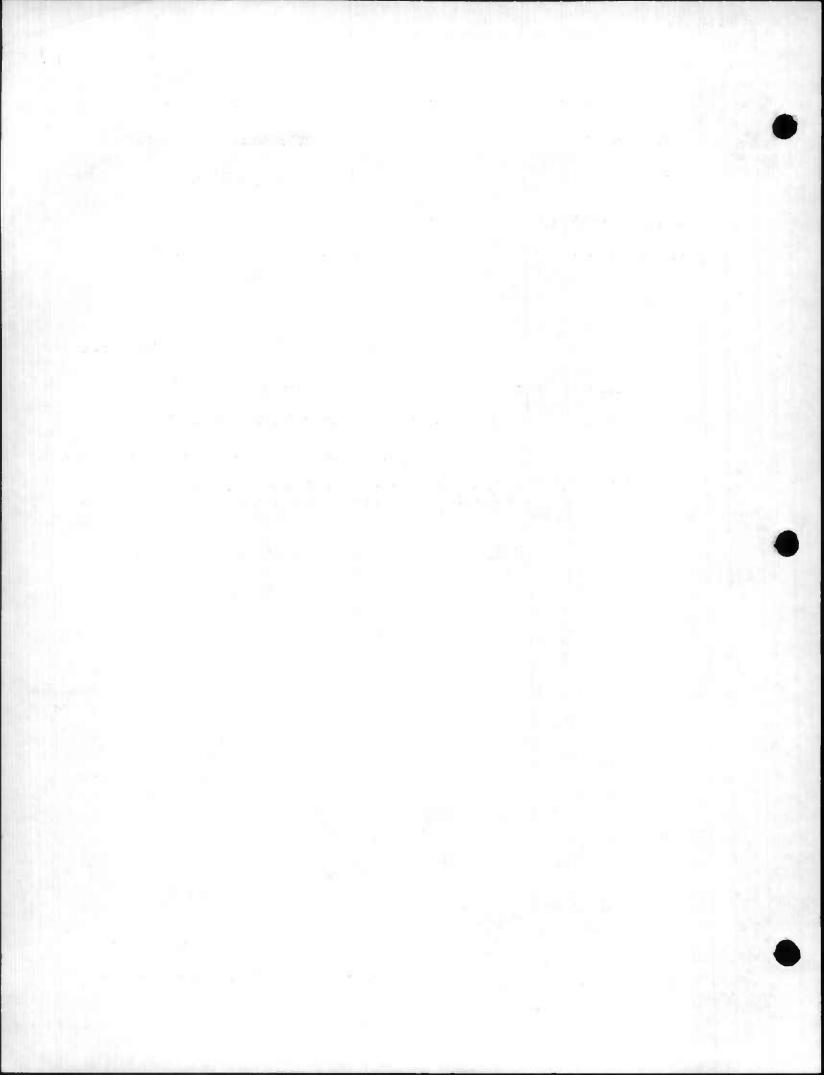
To the Funeral Director: After this certifica complately filled in by the funeral director, p 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 | Inpetient Other: 4 Nursing Home 5 Residence 8 Other (Specify) in 24 hours after death.
The Funeral Director: After this of 10 1 Yes 2 No XER/Outpatient 3□ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending invastigation 1 Neturat 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as alated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner estated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) NOV. 7, 1997 0 O.C.M.E 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 1JUN.K row les

State Registrar

31. Date filed (Month, Day, Year) NOV 10

32. Registrer's Signature rulia Davidson-Randone



29d. Data signed (Month, Day, Year)

Examiner

Funeral

Director

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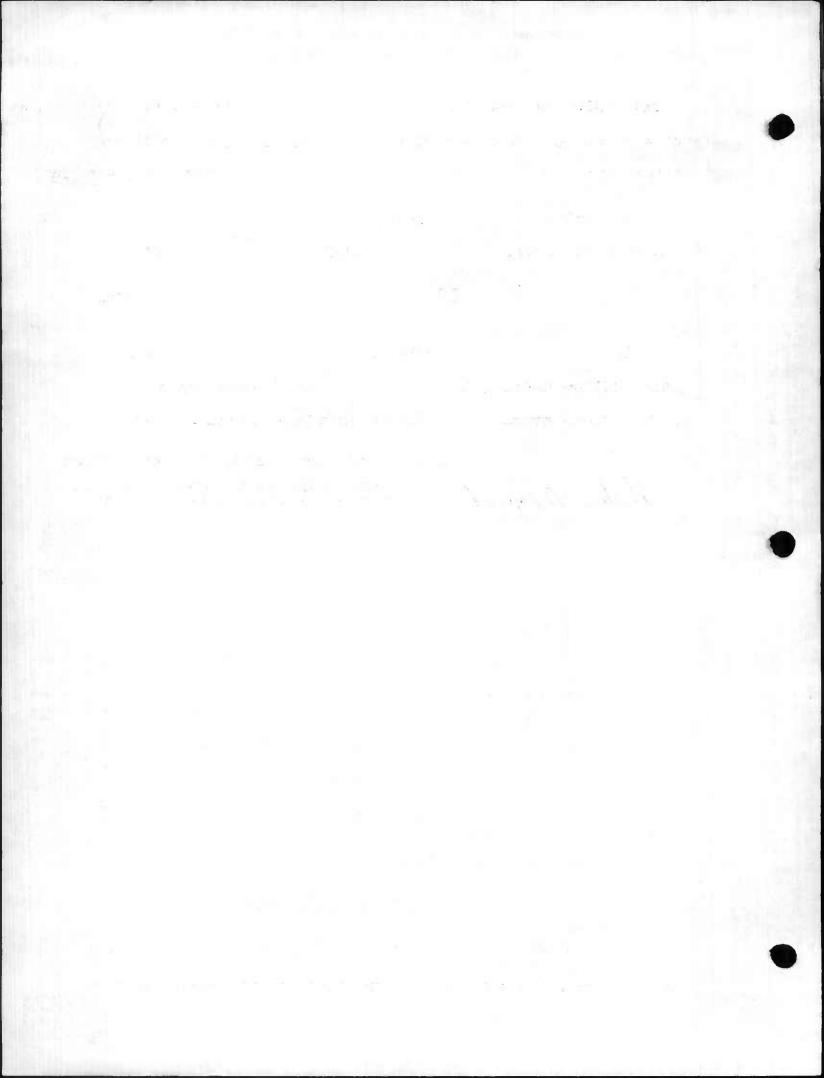
7 is marked other than "natural", or items 23s or traumatic event, the Medical Examinar must be or Completed Elamantary/Secondary (0-12) Collega (1-4or 5+) Hygiene. Salesman Department of Health and Mental Hy Important: If them 27 is marked othe any injury or other to 17. Father's Nema (First, Middle, Last) Harold William Rawlings, Sr. 19a. Intormant's Name/Raiatlonship (Type, Print) Kim A. Rawlings/Daughter 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Spacify) Hilltop Service Corp. 21. Signeture of Funeral Sarvice Licensee Physician /Medical immediata Causa (Final ENDSTAGE CARDIOMYOPATHY diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Sequantielly list conditions, if eny, leading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t þ Completed peed has page 2 certificate Hospital or Attending Physician: Be 25. Was casa referred to medical examiner? Hospitel: Certification: To 1 Yas 2 No 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? Affer 1 Natural 2 Accident 5 Panding death. 1 ☐ Yas 2 ☐ No investigetion ofter death Director: / 6 Could not be datermined 3 Sulcida 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 3 4 Homicida To the Hospital or within 24 hours eff To the Funeral Di completely filled in 152 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of exeminetion and/or invastigation, in my opinion, death occurred at the time, dete and piece, and due to the causa(s) and mannar stated, 29e. Cartifler Medicai 29b. Signature and titla of certitian 29c. Licansa number doon (e and tima 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) CAROLINA CUSTODIO, M.D. 9600 NORTH POINT RD FORT HOWARD, MD 21052 32 Floring Asignature Ravdall 31. Data filed (Month, Day, Year) State

Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death NOVEMBER 13, 1997 Physician Harold William Rawlings, Jr. 11:10 AM /Medical 4e. Fecllity Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death VA MARYLAND HEALTH CARE Baltimore SYSTEM FORT HOWARD If Undar 1 Yaer | If Undar 24 Hrs. | 8. Data of Birth Months Deys Hours Min. (Month, Day, Year) 5. Sociei Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Deys 1√2 M 2□ F 25,1938 59 Yrs Maryland 219-26-7226 Usual Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 217 No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 710 West Baker Avenue 21009 USA Funeral 12. Was Decedent Ever In U.S. Armed Forcas? 1 (X Yes 2 □ No 1956— If Yas, Giva Yeer or Detes: 1962 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indian, Bleck, Whita, atc. 11. Marital Status 1 Nevar Married 2 Merried 1 ☐ Yas 2 ☐ No Specify: Specify: White p 3 ☐ Widowed 4 ₺ Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Automotive 18. Mother's Nama (First, Middla, Maiden Surname) Lottie Laina Saukko 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 350 Ambleside Lane, Aberdeen, MD 21001 20c. Location - City or Town, Stata 11/15/97 Towson, Maryland 22. Nome and Address of Facility
Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23e. Part1. Enfar the disease, or complications the Jused the deeth. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause of each line. Approximate interval Between Onset and Deeth 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 Probably ♦ Unknown 24b. Wera sutopsy findings svallable prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

Registrar

NOV14



State of Maryland / Department of Health and Mental Hygiene

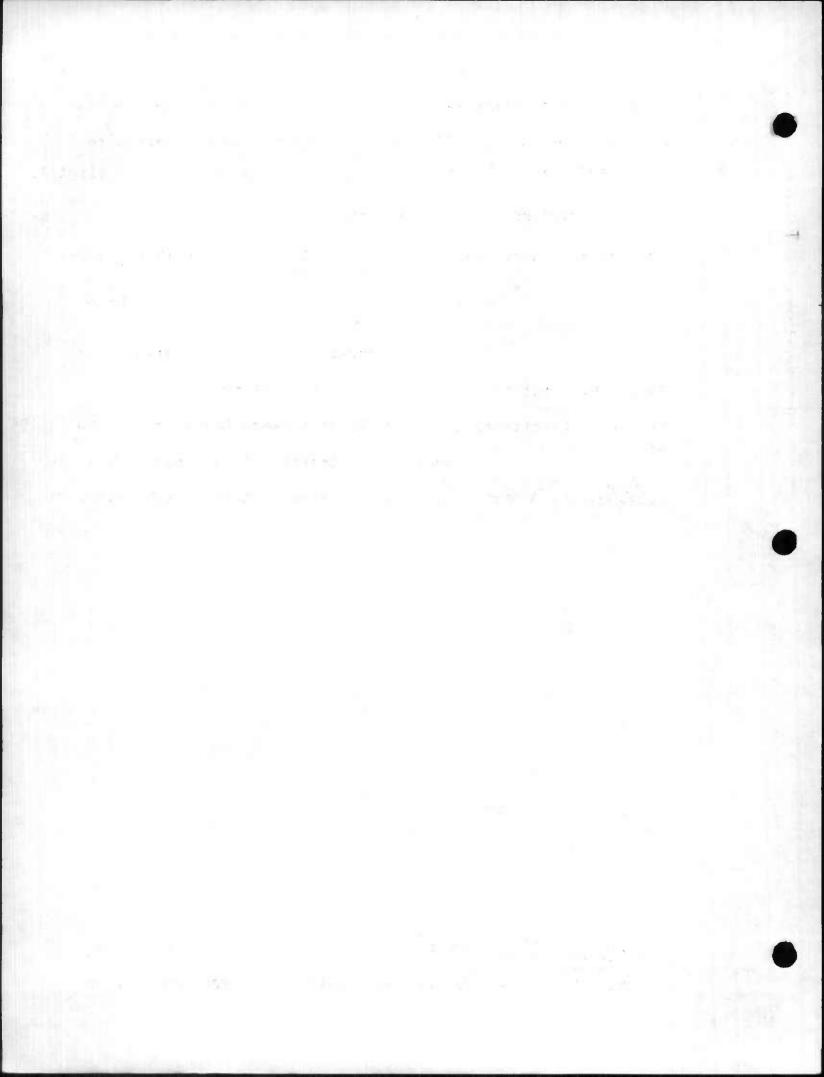
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 31 1997 Month **Physician** October GLENWOOD J. RATCLIFFE 6:30 pm /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM HOWARD Baltimore FORT if Under 1 Yeer | if Under 24 Hrs. 5. Sociei Security Number 9. Birthpiece (State or Foreign Country)
21 Virginia 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev. Year) **Funeral** Deys 1 M 2 □ F Director 219-10-5939 26,1921 76 August Usuel Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at MD Harford Street 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3438 Grier Nursery Road 21154 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 2 Yes 2 □ No If Yes, Give Yeer or Detes: 1 TX Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify:White by 3 ☐ Widowed 4 ☐ Divorced WW II Completed 15. Decedent's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If fem 27 is marked other than any Injury or other traumeti. Elementery/Secondery (0-12) College (1-4or 5+) 6 Various Laborer 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be 2 Edward H. Ratcliffe Dora Clark 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21154 Oliver B. Ratcliffe/Bro. 3438 Grier Nursery Road, Street, MD Baltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriai 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Deer Creek Cemetery 11/4 Forest Hill, MD 21. Signature / Funerei Service Licensee 22. Neme and Address of Fecility Harkins Funeral Home, Ir Harkins Funeral Home, Harkins Funeral Home, Inc., Delta, PA interval Between Onset and Deeth **Physician** immediate Cause (Finel disease or condition resulting in death) /Medical Parkinsons Disease Examiner Due to (or es a consequence of): Becurrent Pneumonia Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last and Due to (or es e consequence of) physician a Box 68760 Carcinoma of Larynx The law requires that the death certificate be Physician/Medical Due to (or as e consequence of): attending i P.O. I Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ been sig Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? has page 2: 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours effect death.

To the Funeral Director: After this certifical completely filled in by the funeral director, I Be 25. Wes case referred to medical exeminer? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 Yes 20 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28c. injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending Investigation 1 Neturei 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end menner steted. 29e. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) October 31,97 18 30. Name and eddress of person who complained cause of deeth (item 23a) (Type, Print) Augustin Chyu, M.D. VA Maryland Health Care, Fort Howard, MD 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State

DHMH 16 Bay 6/95

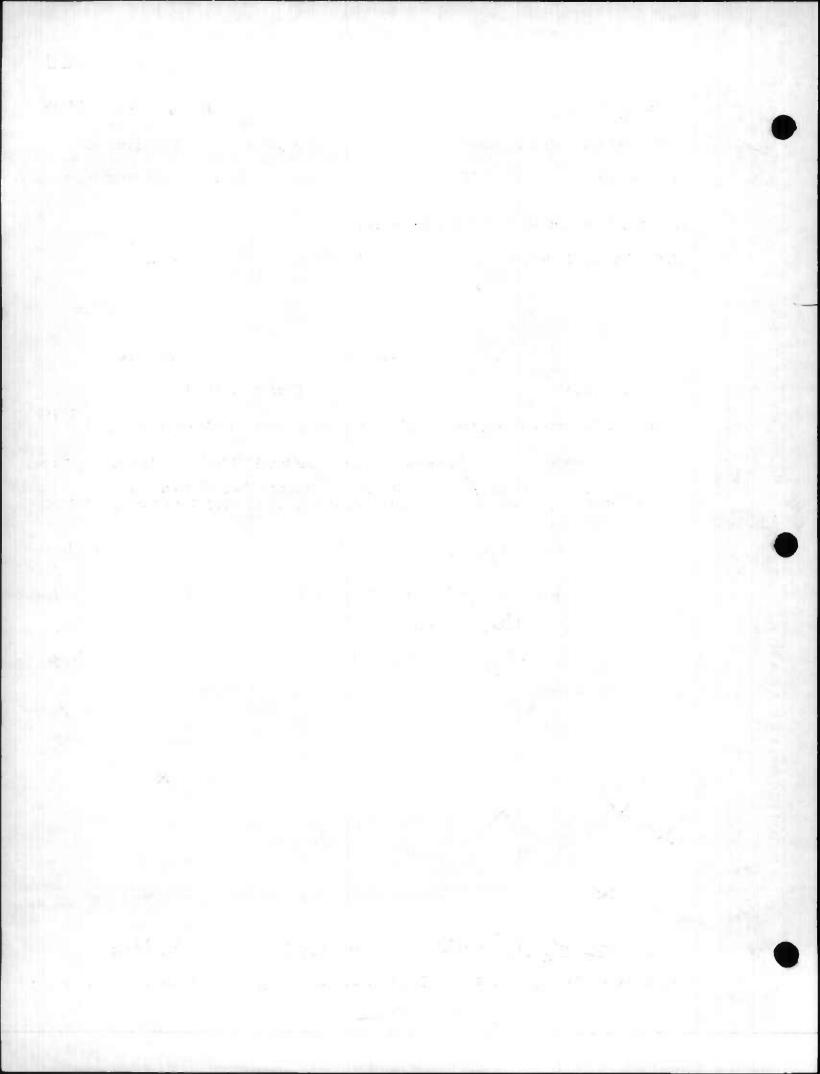
Registrar

Glenwood Rarcliffe



State of Maryland / Department of Health and Mental Hygiene 97 35720

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		ecedent's Name (First, Middle, L							2. Date of De	ath Day	Year	3. Time of De
/Medical		Mory Rogers	****						11	6	97	13:18
xaminer	4a. F	acility Name (If not institution, g	ive street and number)				4b. City, To	own, or Lo	ocation of Death	4c. Cou	nty of Death	
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neral			Sax 7. Age (1 1 M 2 F F	In yrs. last bin	thday) If Unde Yrs. Months			24 Hrs. Min.	(Month, Da			placa (State or F ntry)
ector		9-14-2445 al Rasidence of Decedent	77		110.				March	30,192	OWashi	ington,
Š 18		State 10b. County	1	0c. City, Town	n or Location							10d. Insida City i
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be notified	10e.	Street and Number	mdei .	Davius		p Code				10g. Citizen	of What Cou	ntry?
		26 Lake Forest	Drivo		2	1035						
ricer must	11.1	Marital Status	12. Was Decedent Eve	er in U,S.	13. Was Dace	dant of	Hispanic Or	igin? (Sp	ecify Yes or No-	U.S.	A lace - Ameri	can Indian,
J.		☐ Nevar Married 2☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No						Rican, atc.)	E	lack, White,	etc.
edical Examinet must be notified at letted by Funeral Director		Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 🔯 No	Specify.			Spe		hite
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event, the Medical Be Completed	E	ementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	ise retir	ed)	St OF WORK	ing			
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10		Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place of	Disposition (Na y, crematory or o	ma of			Date	20c. Location		
Ž.		4 Donation 5 Other (Spec		Lakemo	nt Memoi	cial	Gard	ens l	1/10/97	David	sonvil	le. MD
any in	21. 5	Signature of Funeral Service Lice		7	22. Name a	nd Addr	ess of Facili	ity				
58		Willia	7 BV						Funeral			
	23a	Part1. Enter the diseasa, or cor shock, or heart failure. List only	nplications that caused the	e death. Do r	not enter the mod	da of dy	ing, such as	cardiac	. Sl. و . W و . or raspiratory ar	rest,	pring,	MD 2090 Approximate
Ician	1	Shock, or near failure. List one	y ona causa on aach line.									Intervat Betwas Onset and Des
dical		ediate Cause (Final ase or condition	51	9 4								
niner			11000	- K								1 day
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<u> </u>	resu	alting in death)	Du	e to (or as a	consequence of).	-	lve					
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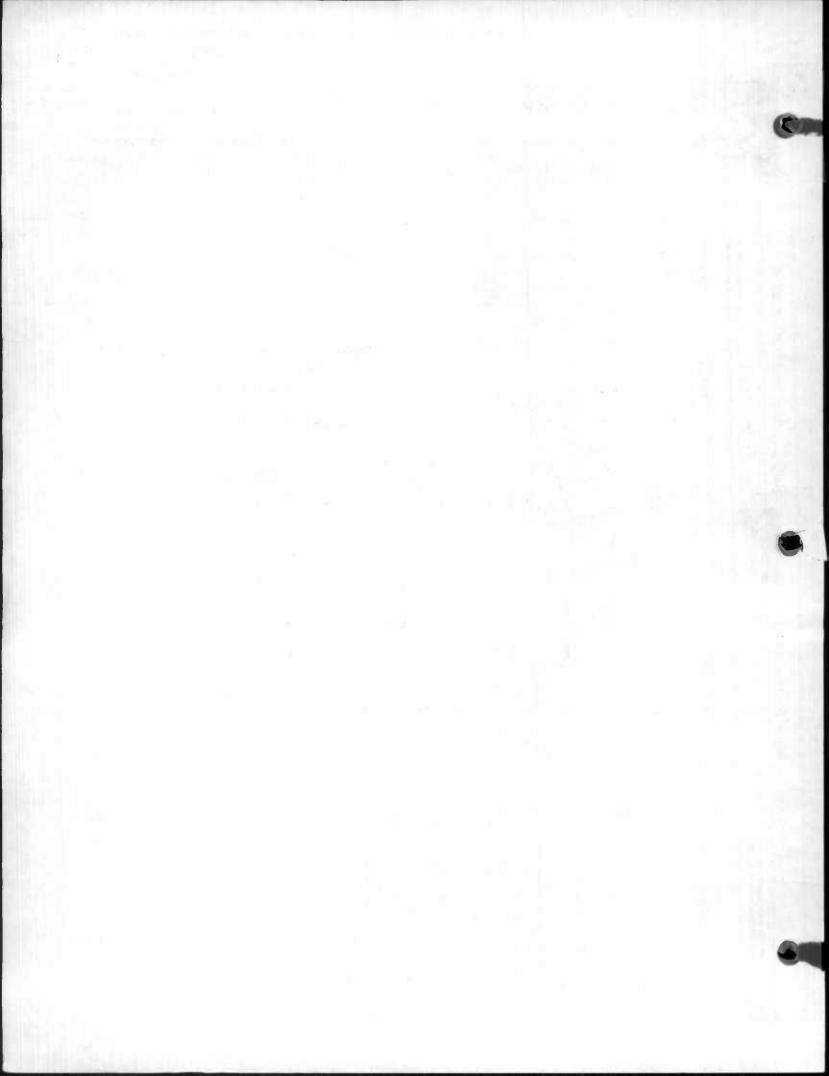


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death RESSACAM Month **Physician** KUNHATHUKA 7.28 AM 67-/Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Hours Min. 8. Data of Birth (Month, Dey, Feb. /) If Under 1 Yaar 5. Social Sacurity Number 9. Birthplace (Stete or Foreign Country) India 7. Aga (In yrs. last birthday) **Funeral** Months Days 1 ☑ M 2 □ F 578-98-9559 Yrs. Director Usual Rasidence of Decedent pemit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiena. Important: If itam 27 is marked other than "natural", or itema 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be not traumatic event, the Medical Examiner must be not traumatic event. 10b. County 10c. City, Town or Location 10d. Insida City Limits 1X Yes 2 □ No Maryland Takoma Park Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8111 Hammond Avenue 20912 India Funeral 12. Was Decadant Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, White, atc. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: Baltimore, Maryland 21215-0020 1 ☐ Nevar Marriad 2 X Married 1 ☐ Yes 2 No p Specify Asian/Indian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) High School Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Samuel Ressalam Unobtainable 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 8111 Hammond Avenue, Takoma Park, Maryland 20912 Raju Ressalam / Son 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial Camation 3 Removal from State 5 Other (Specify) George Washington Cem. 11/11/97 Adelphi, Maryland Nama and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Fuseral Service Light 11800 New Hampshire Avenue Silver Spring, Maryland Sliver Spring, Maryland 20 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, lim only one cause on each line. Approximate Intarval Between Onset and Death **Physician** 5E12URE DISOFDER /Medical Immediate Cause (Final Horry disaase or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequença of): HYPERMENSION Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): ROSTATE signed by the et d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PROSAME SPECIFIC PIMICEN 1 Yes 25 No 3 Probably 4 Unknown p 24b. Wera autopsy findings available prior to complation of causa of death? 24e. Was an autopsy performed? Completed TRAIK INFECTION 1 🗆 Yas 2 KINO 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Plece of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of Injury 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Ratural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, State) 4 | Homicide to Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner as stated.

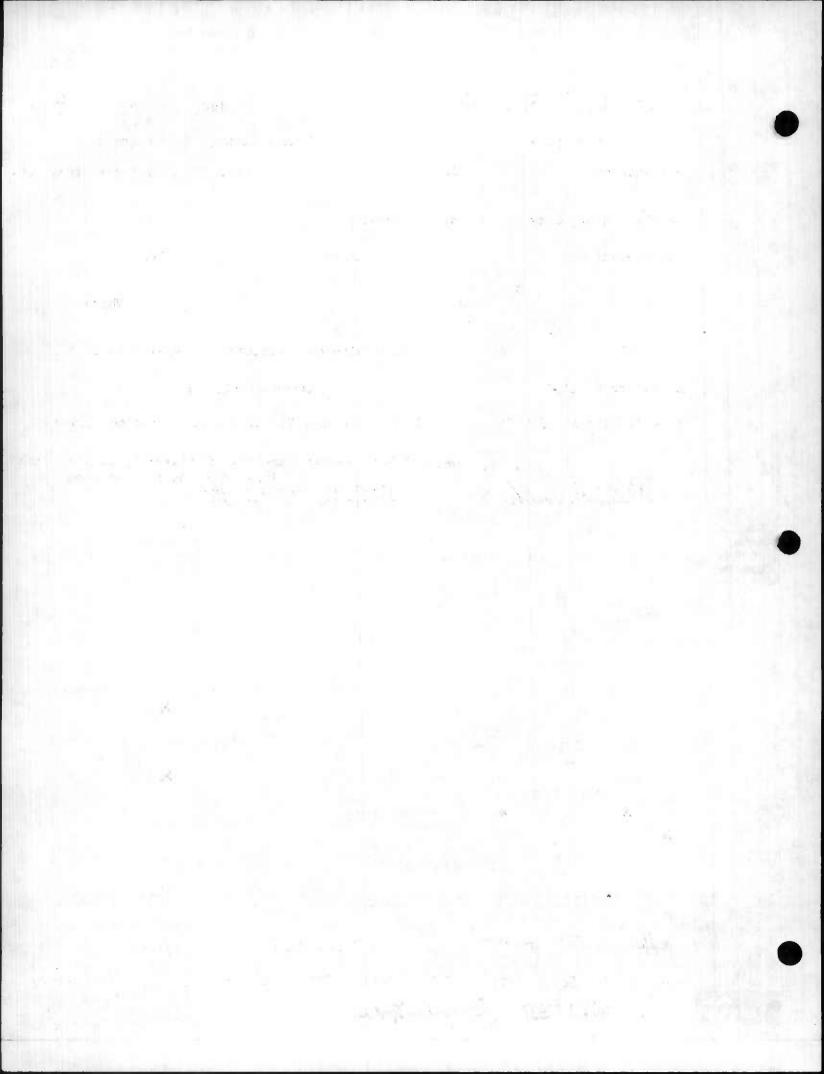
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signatura and titla of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POLL AXE = 230

KSUDHAKAR M.P. 7610 CAPPOLL TAKOMA DIRK MO 20912 KSUDHAKARM.P. 7610 31. Data filed (Month, Dey, Yaar) 32. Registrar's Signature State NOV12 Julia Davidson



State of Maryland / Department of Health and Mental Hygiene 7 35722

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THE REAL PROPERTY.	4	Holy Cross Hosp:				f Under 1 Year	Silver	Spring	Mont	tgomer	
Funeral Director	-	5. Social Security Number 307-10-8297 Usuel Residence of Decedent	M 2□F	82		n Onder i Year Nonths Deys	Hours Min.	8. Dete of Bird (Month, De Sep • 29	, 1915	9. Birthple Country Washii	ce (State or Foreign y) ngton, D.
death with the Maryland rms 23a or 28a-f show Lives to notified at neral Director		10e. State 10b. County		10c. City	, Town or Locati	ion				100	d. Inside City Limits
Man Han	Ö	Maryland Montgome	ery	Sil	ver Spr	ing					1 ☐ Yes 2 ☐ No
r 28g	9	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Country	y?
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P 4 8 1	y runer	11. Maritel Status 1 Never Merried 2 Married	12. Wes Deceden Armed Forces 1 X Yes 2 If Yes, Give	? No	If Ye	S Decedent of less, specify Cub	Hispenic Origin? (S en, Mexicen, Puert Specify:	pecify Yes or No- o Ricen, etc.)	14. Red Ble	ce - American ck, White, etc	c.
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trau		Iris B. Rinaldi					ay, Silve				20904
Hear tem to	-	20e. Method of Disposition	/ WIIC	20b. Pl	ece of Disposition			Dete	20c. Location		
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Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examples. To Be Completed by F	1	21. Signeture of Funeral Service Licer	0	1000	22. No.	ame end Addre	ess of Fecility Hi Hampshi	nes-Rina re Avenu	ldi Fun		
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After the funeral		27. Menner of Deeth 1 Menner of Deeth 5 ☐ Pending	28e. Dete of Inju (Month, De	ury ey Year)	28b. Time of Injury	28c. Injui	y et rk?	28d. Describe h	ow injury occur	red	
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is efter death. al Director: After to do in by the funeral Certification;		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of in	jury - At hon	ne, ferm, street,	factory, office		28f. Location (S City or Tow		er or Rural F	loute Number,
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within 24 hours efter de To the Funeral Directo completely filled in by th Medical Certific	1	29b. Signeture end title of certifier	0	V		29c. Licens		- 2	29d. Dete signe	d (Month, Da	y, Year)
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State	3	31. Dete filed (Month, Day, Yeer)	32. Regis	rer's Signatu	ire				1		



Physician /Medical Examiner	
Funeral Director	

1. Decedent'a Neme (First, Middle, Last) 2. Date of Death NOV. 11, 1997 GEORGE 7:25 AM E. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE
If Under 24 Hrs. 8. Date
Hours Min. (Mon MONTGOMERY If Under 1 Year Months Days 8. Data of Birth (Month, Day, Year) OCT. 10,1921 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country)
 MASS. 1MM 2□ F 015-05-9189 76 Yrs Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or heme 23a or 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director MD. MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter deeth v Department of Health end Mentel Hygiene.
Important: if item 27 is marked other than "natural" and other traumatic avairable. 2877 20850 GLENORA LA. U.S.A. Funeral 14. Race - Amarican Indian, Black, White, etc. Was Decedant Evar In U.S. Armed Forcas? 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puarto Ricen, atc.) 11. Marital Status 1 MYes 2 No If Yes, Give Year or Dates: WWII 1 Navar Married 2 Married 1 ☐ Yes 2 ▼No Specify: by 3 Widowed 4 Divorced WHITTE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ HEALTH SCIENCE ADMINISTRATOR N.I.M.H. 18. Mother'a Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EMILE RENAUD 2 REGINA ST. ONGE 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) DOROTHY R. RENAUD/WIFE #10 SAME AS TTEM 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 【Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 11/12/97 RIVERDALE. MD. 21. Signature of Funarai Service Lighnsee 22. Name and Address of Facility 20910 M00091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23a. Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaese or condition resulting in death) · Pontine hemorrhage one wk Examiner Due to (or as a consequence of): Examiner huper ten sion 20 4FS physician end the burief-transit the deeth certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): for use es Part II. Other algnificant conditions contributing to death but not resulting in the undarlying causa given in Part i. ed by the e Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Tyes 2 PNo 3 □ Probably 4 □ Unknown brillation, counadin therapy þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? Completed peen hes certificate 1 Yes 2 No 1 ☐ Yes 2 BNo Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certific director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2€No 2 1 Inpatient 2 □ ER/Outpatlent 3 □ DOA in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Metural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours elemental To the Funeral D completely filled is 29a. Cartifier 1 Cortifying Physician: To the best of my knowledga, daath occurred at the tima, date and place, and dua to the causa(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) November 11, 1997 D33443 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Viers Mill Rd, Rockville, md 20851 Pollack, m.O. 809

32. Registrar's Signature

Julia Davidson

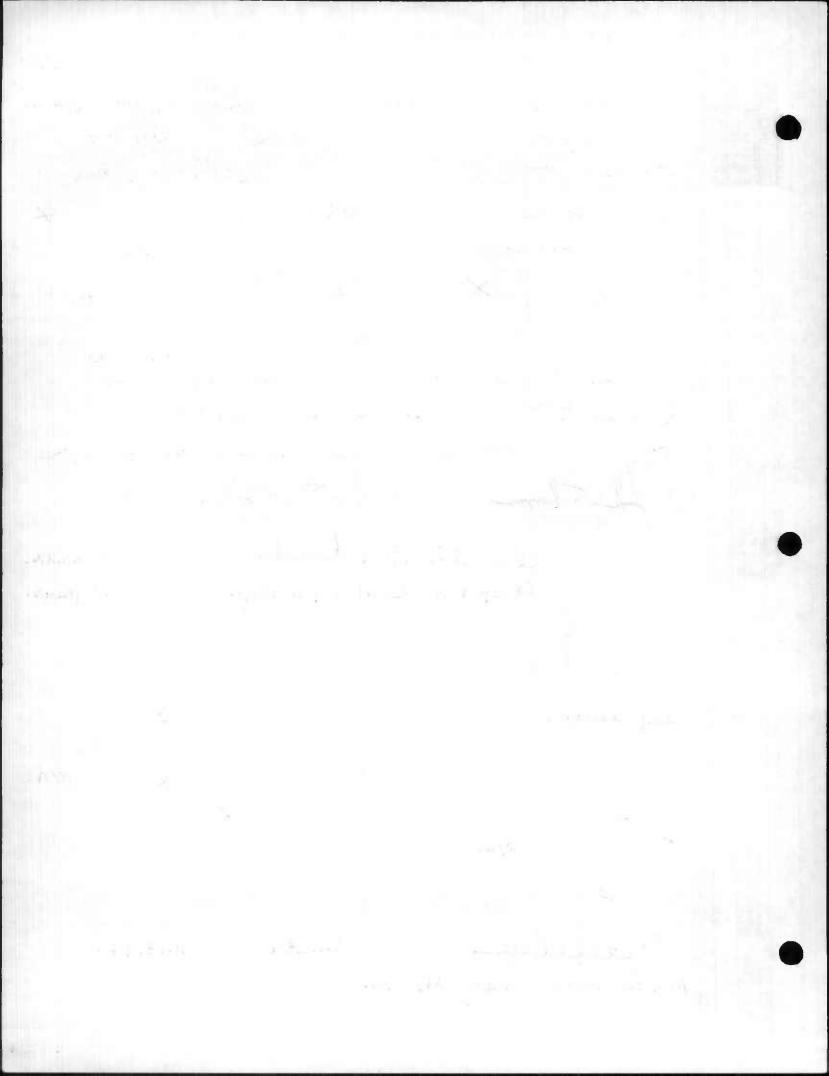
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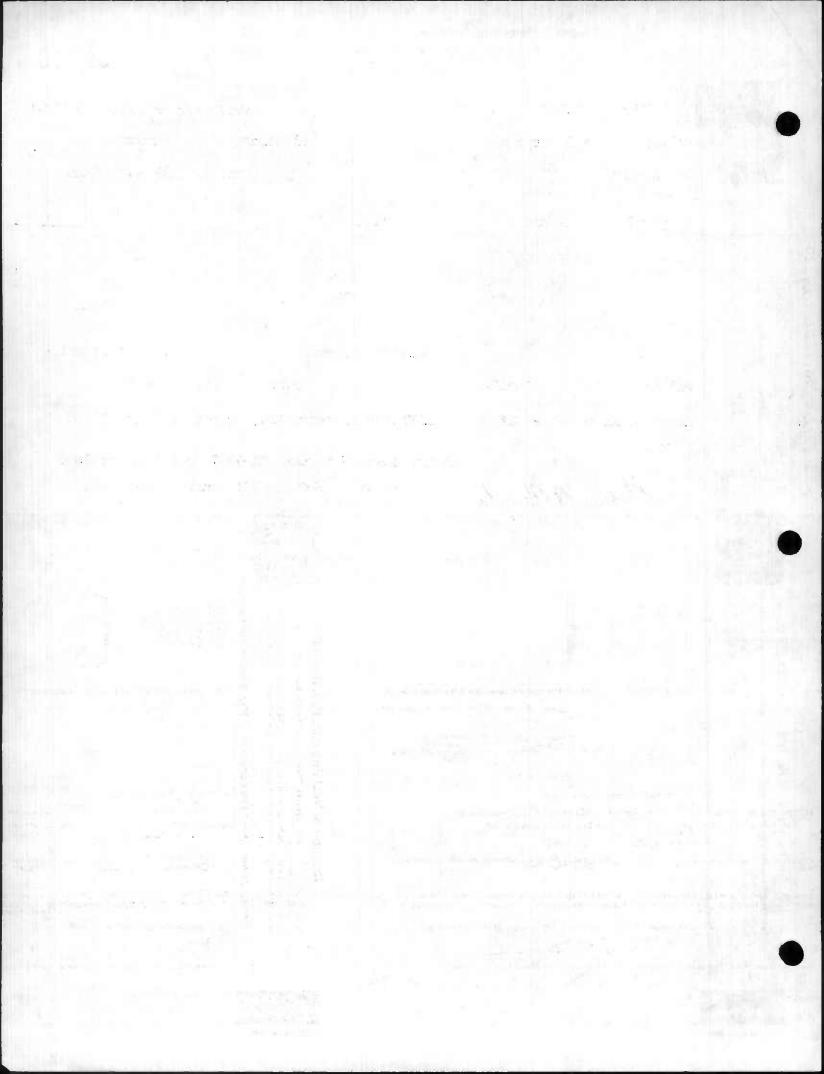
State of Maryland / Department of Health and Mental Hygiene 97

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	/Medic Examir		4e. Fecility Neme (of the state of th							own, or L	ocation of Deeth	4c. Count	y of Death chest	
	uneral		5. Social Security N	lumber 6.	Sey 10 M 2□ F		s. last birthday) Yrs.	If Und Month	or 1 Yea s Days	r If Under		8. Dete of Bird (Month, De July 1		9. Birth	plece (Stete or Foreign
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permit. Pag Department	Important: eny injury once.		21. Signature of Fe							ess of Fecili			MD 216	12	
			23e. Pert1 Enter t	he disease, or con	nplications that	caused the de	1					bridge,		113	Approximete
Phy:	sician		shock for hee	ert feilure. List only	one ceuse on e	ech line.	11		,						Intervel Between Onset end Deeth
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redn	should	Completed											en eutopsy rmed?	6/	Vere autopsy findings vellable prior to completion of cause
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	등 등		27. Manner of Deet	h	28e. Date		28b. Time of		28c. Inju		arsing ric	28d. Describe			77
Attending or deeth.	vr: After he funer	atio	1 Neturel 2 ☐ Accident	5 Pending Investigation	n N/	A.	Injury	М		Yes 2	No				
at o	d Director:	Certification:	3 Suicide 4 Homicide	6 Could not I	280. Place	of fnjury - At ing, etc. (Spec	home, farm, str ify)	eet, facte	ory, office			28f. Location (S City or Tox		ber or Run	el Route Number,
To the Hospital within 24 hours	To the Funers! I completely filled	edical	29e. Certifier (Check only one)	1 Cartifying Pi 2 Medical Exa	miner: On the b	best of my kn asis of exemin ner stated.	owledge, deeth etion end/or inv	occurre restigetion	d et the ton, in my	ime, dete en opinion, dea	d plece, th occur	end due to the red at the time,	cause(s) end m date end pleca	enner es s , end due t	iteted. o the cause(s)
To the	To the comple	Me	29b. Signeture end	title of cartifier				2	9c. Licer	ise nu <i>m</i> ber			29d. Dete sign	ed (Month,	Dey, Year)
) i C	2020	lee				B	11128	34		11.13	.91	
12	,		30. Neme end addr	ess of person who	completed caus	se of death (Ite	m 23a) (Type,	Print)							
			1	BINSON	JIW V	te-	MD '	PA.							
	Sta		31. Dete filed (Moni	NOV Year) 4	1997 32.5	egistrer's Sign	Bys-Rard	all							
- 1	Renistr	212			1991										



ician		1. Decedent's Name (First, Middle,	Last)		201	tificate of	Joan	2. Dete of D		3. Time of Death
dical niner	ŀ	MELVIN WY la. Fecility Neme (If not institution,		EFFER			4b. City Town o	NOUEM r Location of Dea		1997 635P1
iner		Fallston General		,			Fallst		Hari	
al or	1		-	nge (in yrs. ias	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min	s. 8. Dete of Bi		9. Birthpiace (State or Fore Country) Maryland
		Jsuai Residence of Decedent 10a. Stete 10b. County		100 City	Town or Lo	nation				
o		,	rford	Too. City,		Forest H	277			10d. Inside City Lim 1 ☐ Yes 2 🔯
Director	1	Maryland Ha 10e. Street end Number	riora			10f. Zip Code	TTT		10g. Citizen of V	
		2238 C Rock Spri	ng Road			21	050			JSA
by Funeral		1. Marital Stetus 1 Never Merried 2 XMerrier 3 Widowed 4 Divorced	12. Was Deceden Armed Forces d 1 Yes 2X If Yes, Give Year or Dates:	?] No	If	Vas Decedent of N Yes, specify Cub	en, Mexican, Pue	(Specify Yes or Norto Rican, etc.)		e - American Indian, sk, White, etc. ': White
Completed		15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) Coilege (1-4or		(Give I life. D	ent's Usual Occup kind of work done O NOT use retire	during most of w d)	orking		usiness/Industry
ပိ	1	7. Fether's Neme (First, Middle, La	nst)		Line	man Fore		eme (First, Middle		Government
To Be		Villiam (u/k)	Shaeff	er			Martha			
		19e. informent's Neme/Relationship Hazel B. Shaeff						Pural Route Numb		
		Oe. Method of Disposition		20b. Piac	ce of Dispos	sition (Name of atory or other pla		Dete		City or Town, State
		1 ☑ Buriai 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe		9			-	11-7-97	Bel Air	r, Maryland
	2	21. Signature of the erei Service Lic	Mercel	1	Ho		McComas	III Fur	neral Hon	
		23a. Part1. Enter the disease, or co shock, or heart feilure. List on	empilcations that cause lly one cause on eech i	d the deeth. line.	Do not ente	r the mode of dyin	ng, such es cardi	ec or respiretory a	arrest,	Approximate interval Between
		mmediete Cause (Finei diseese or condition esulting in death)	a^	ufo	t	of Bo	wel			Onset and Death
je				Due to (or e	s a consequ	uence of):				
i Examiner		Sequentially list conditions, I any, leading to immediate ause. Enter Underlying Cause (Disease or injury	b	Due to (or a	s e consequ	ence of):				
edicai	t	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause (Olsease or injury hed initiated events esulting in deeth) Lest	c	Due to (or as						
edicai	t	esulting In deeth) Lest	c	Due to (or as	s à consequ	ence of):				
Physician/Medical	P	esulting in deeth) Lest est li. Other significant conditions		Due to (or as	s à consequ	ence of):	ven in Part I.			
by Physician/Medical	P	esulting in deeth) Lest est li. Other significant conditions	d.	Due to (or as	s à consequ	ence of):	ven in Part I.	1		3 Probably 4 Unknown
by Physician/Medical	P	esulting in deeth) Lest est li. Other significant conditions		Due to (or as	s à consequ	ence of):	ven in Part I.	1	Yss 22No	3 Probably 4 Unknown 24b. Were autopsy finding evallable prior to completion of ceuse
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DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month **Physician** Grace Magnolia Sheetz November 4, 1997
ocation of Death 4c. County of Death 8:50 A.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Undar 1 Year If Undar 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 21XF 75 Yrs. 244-24-1148 Director December 9, 1921 Virginia Usual Rasidance of Dacedant the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic avent, the Madical Examiner must be notified at 1 Yas aF No Director Maryland Harford Churchville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3141 Aldino Road 21028 permit. Pages 1 and 2 should be filed within 72 hours aftar death Depertment of Haalth and Mental Hygiena. If Item 27 Is marked other than "natural; or Items 23. Funerai USA Was Dacedanf Evar In U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Marifal Status 1 Navar Marriad 2 Married 1 ☐ Yas 2 No If Yas, Giva 1 ☐ Yas 2 ☑ No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Board of Education Cafeteria Worker 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Charley (NMN) Waddell Rosie (NMN) Walton 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Mack (NMN) Sheetz - Husband 3141 August 20b. Place of Disposition (Nama of camatary, cramatory or other place) 3141 Aldino Road, Churchville, Maryland 21028 of Disposition (Nama of Data 20c. Location - City or Town, State 20a. Mathod of Disposition any injury or c 5 Other (Specify) Harford Memorial Gardens 11-7-97 4 ☐ Donation Aberdeen, Maryland 21. Signature Funaral Sarvi 22. Nama and Addrass of Facility Howard K. McComas III Funeral Home P.A. Part 1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Dua to (or as a Examiner 1/20 Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last and Dua to (or as a consequence of) physician Physician/Medicai the **88 98**0 ed by the ettending detached for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the tause of death? 1 Yee 20 No 3 Probably 4 Unknown by 8 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Completed 1 🗆 Yas 1 ☐ Yas 2 ☐ No funaral director, 25. Was cesa rafarred to medicef axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 210 No 10 1 Inpatiant 2 ER/Outpatiant 3 DOA 27. Manner of Death Certification: 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding Invastigation 1 ANatural 1 ☐ Yas 2 ☐ No 2 Accident or Attance ofter deatl Director: 6 Could not ba To the Hospital or Attal within 24 hours eftar ded To the Funeral Diractol completaly filled in by th 3 ☐ Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Cartifian l 🖟 Cartifying Phyalcian: To tha bast of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Medicai 2 Medical Examinar: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stafed. 29b. Signat 29c. Licensa number 29d. Date/signed (Month, Day, Year)

plajed cause of daath (Itam 23a) (Type, Print)

32. Registrar's Signature

1104

State Registrar

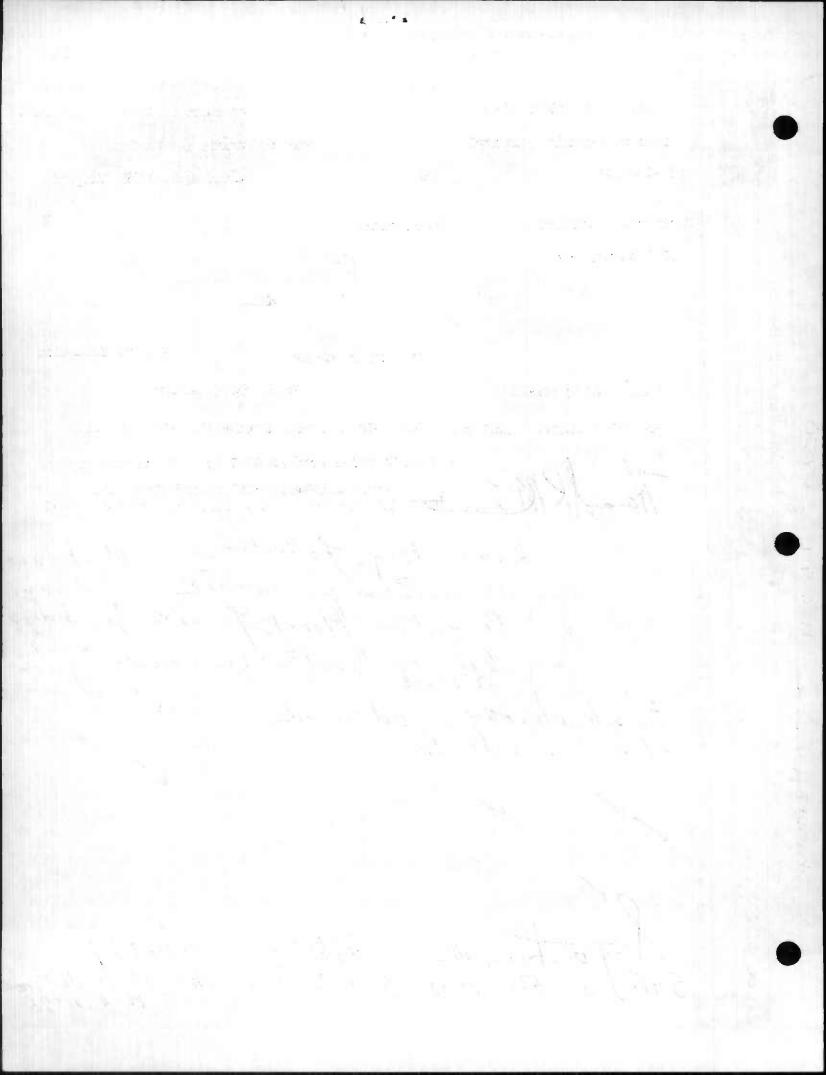
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** BRYAN LEE SHOCKLEY OCTOBER 29, 1997 10:35 A.M. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND GARRETT Hours Min. 8. Data of Birth Month, Day, If Under 1 Year 5. Sociel Sacurity Number 7. Age (in yrs. last birthday) 9. Birthplaca (State or Foreign Country)
Maryland **Funeral** Days M 2□ F Months 236-12-9201 88 Director Usuai Rasidance of Decadant death with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford MD. Forest Hill 28a-f 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò 1619 Kreitler Valley Road 238 21050 U.S.A. Funeral 12. Was Dacedent Ever in U,S. Armed Forcas?

1 Yas 2 No If Yas, Give items ; Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Reca - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiens. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event. 1 Never Married 2 Married 1 ☐ Yas 2 No Specify by Specify: Caucasian 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary School Elementary/Secondary (0-12) Collega (1-4or 5+) 12 School Principal Baltimore County 6 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Malden Surname) Be John Merrill 0 Shockley Sarah Elizabeth Fooks 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert Lee Shockley/Son same as 20b. Placa of Disposition (Name of cemetery, crematory or other placa) Data 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Othar (Specify) Holly Hill MeM. Park 11/3 Middle River, Md. 22. Name and Addrass of Facility Kurtz Funeral Home, P.A. 21. Signatura of Funeral Sarvica Licansee Jarrettsville, Maryland 23a. Pert1. Enter the disease, or complications that cause in a death. Do not enter the mode of dying, such as cardlec or respiratory arrest, shock, or heart failure. List only one cause on each light. Approximeta Intarvel Batwean Onset end Death **Physician** /Medicai Immediata Causa (Finei Dehydration diseasa or condition rasulting in death) 2 days Examiner Dua to (or as a consequanca of): Severe Dementia, Multiple Infarct 10 years The law requires that the death certificete be axecuted Sequantially list conditions, if eny, laading to immediata causa. Entar Underlying Ceusa (Disaese or Injury that initiated avants rasulting in death) Last and the burial-tran Dua to (or as a consequence of): P.O. Box 68760. igned by the ettending physiclan be detached for use as the buria Physician/Medical Due to (or as a consaquenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by 1 Yes 2 No 3 Probably 4 Unknown Multiple CVA's, Hypertension Division of Vital Records, à Completed 24b. Wera autopsy findings available prior to 24a. Was an autopsy parformed? complation of cause of death? certificata hes 1 🗆 Yes 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was casa referred to medical 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yas 2 No 1 Impatiant 2 ER/Outpatient 3 DOA After this tha funeral 27. Mannar of Deeth Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. injury at Work? 28d. Dascribe how Injury occurred Natural 5 Panding invastigation deeth. 1 Tas 2 No 2 Accident within 24 hours after deet To the Funeral Director: 6 Could not be detarmined 3 Sulcida 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida the Hospital Pertifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the causa(s) and manner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the causa(s) and manner stated. Medical 29e. Certifier (Check only 29b. Signature and titla of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) Vun D26650 10/29/97 30. Name and address of purson who completed causa of daath (item 23e) (Type, Port) Margaret W. Kaiser, M.D. 13079 Garrett HIghway Oakland, MD 21550 31. Data filed (Month, Day, Year) State

Registrar

NOV 5 1997

32. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 3 5 7.28 State of Maryland / Department of Health and Mental Hygiene Amend #19a, 11/21/97, BMW, Montg. Co Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Hilda 3:00 AM Singer · November 13, 1997 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 6903 Newberry Drive Columbia Howard 8. Dete of Birth (Month, Pay, Yeer) 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) Delaware 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 F 052-16-8815 75 Yrs. Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at X2 Yes 2 □ No Director Maryland Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6903 Newberry Dr. 21044 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. pemit. Pagas 1 and 2 should be filed within 72 hours aftar to Department of Haalih and Mantal Hygians. Important: if Item 27 is marked other than "natural", or the any Injury or other traumatic event, the Magical Exerctions. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Analyst. US Government 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumame) Nathan Snyder Lillian Brautman 19a Informent's Name/Relationship (Type, Print) Michael Singer 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (Son) 11175 Columbia Pike, Silver Spring, MD. 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete to Buriel 2 ☐ Cremetion 3 ☐ Removel from State Judean Memorial Gardens 11-14-97 Olney, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee Danzansky-Goldberg Mem. Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Onset and Deeth **Physician** /Medical Congestive heart failure tmmediete Ceuse (Final 5 yrs. diseese or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lesf physician and s the burial-tran Due to (or es e consequenca of): P.O. Box 68760, cartificata be Physician/Medicai Due to (or es e consequenca of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 D Onknown Records. þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Lymphona obstructive pulmonery direase 1 Yes 2 1€10 1 ☐ Yes 2 ☐ NO Division of Vital 25. Wes case referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No P in by tha funarai 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: Aftar 1 5 Pending investigation 1 Naturel daath. 1 ☐ Yes 2 ☐ No 2 Accident after daath 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di complataty filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier 2 Madical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the fime, date end piece, and due to the cause(s) end menner stated. 29b. Signeture end fifle of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

Internist

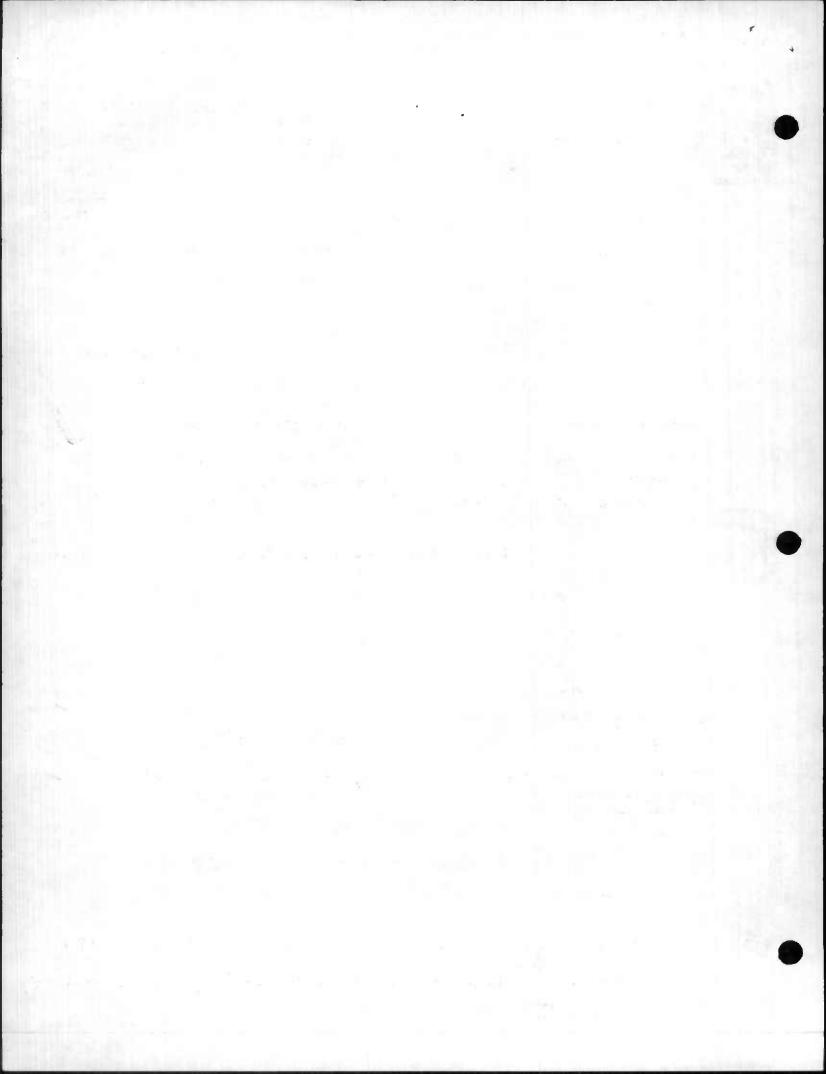
Oruce concering. Suite 210 11055 Little Patricent Plany Colon 9:2, MD 2:044

Nov 13, 1997

State Registrar Buch Congus

31. Dete filed (Month, Day, Year)

30. Neme end eddress of person who collected cause of deeth (Item 23a) (Type, Print)

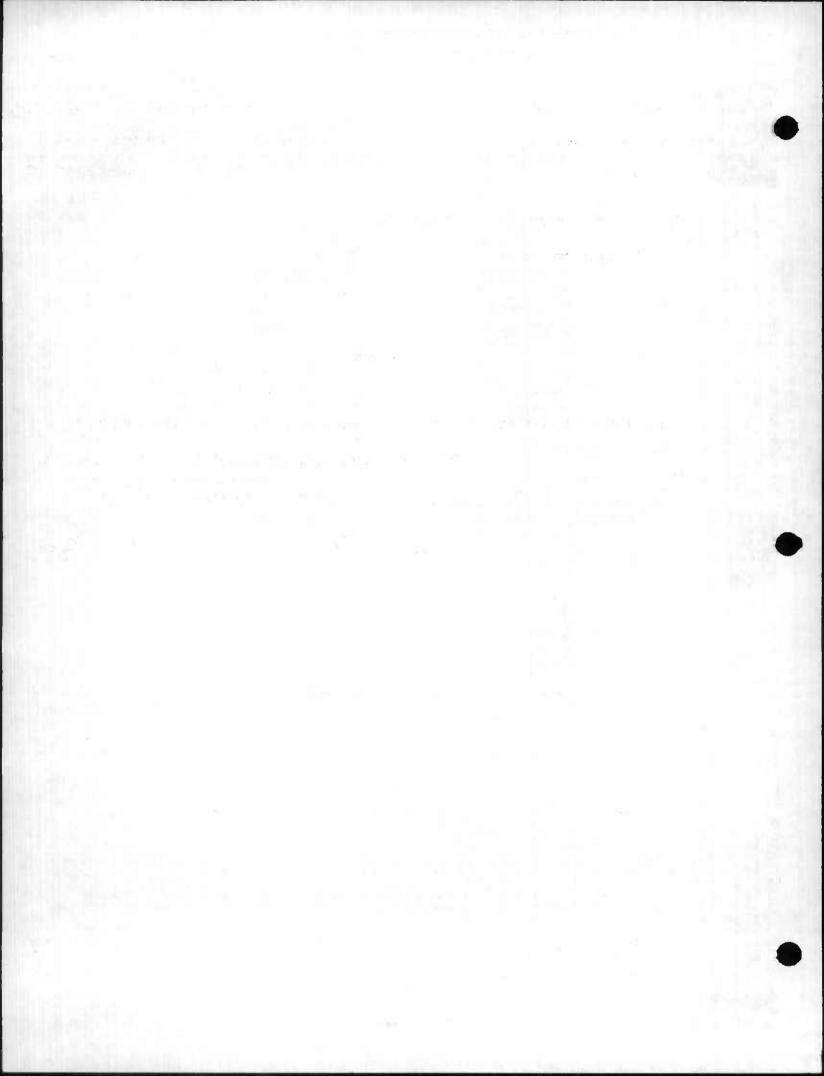


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 7 3 5 7 2 9

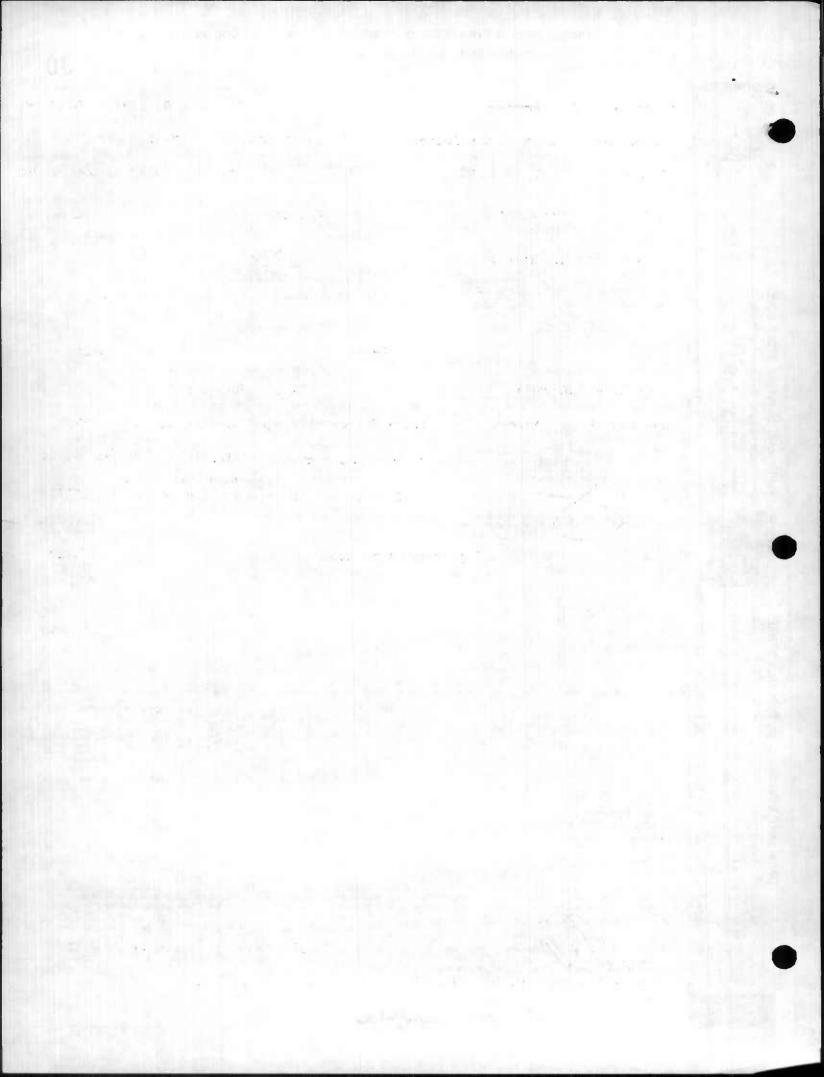
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	Funerai Director		5. Social Sacurity Number 577-70-0993 Usuel Residence of Dacedant	6. Sex 1 □ M 2 🔀 F	Age (In yrs. lest	birthday) Yrs.	If Under 1 Ya Months De			1949	9. Birthpl Count Wash1	ace (Stata or Foreign ngton, DC
land	¥ 11		10e. Steta 10b. County		10c. City, To	own or Lo	cation				10	Od. Inside City Limits
уче Малу	Sa-f sh offilied a	Director	Maryland Monto	pomery	Tako	oma P						1 X Yas 2 No
oth with t	23a or 28a-f show		10e. Street and Number 7520 Maple A	ve. # 215			10f. Zlp Cod	12		U.S.		ry?
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Maryland 21215-0020 od 2 should be filed within 72 hours ef	Wental intendio iffic evv	To Be	Frank E. Will	,				- 12425	et E. Stor		,	
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pemit	Depart Import any inj once		21. Shrintura of Funaral Sarvice	Licensee	bull				Takoma Fun V Washingt			
//	ysician Medical taminer	er	23a. Part. Enter the disease, or shock, or heart faulira. List immediate Causa (Final disease or condition resulting in death)	complications that caused only one cause on each	sed the death. Dh iina. C ZU Dua to (or as	ne	Dis	dying, such as cerdi	ec or respiratory arra	st,		Approximata Intarval Between Onset and Death
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2	ath. r: After t e funera	ation:	27. Manner of Deeth 1 Natural 5 Panding 2 Accident Investig		njury Day Year) 28t	Tima of Injury		njuryet Vork? □Yas 2□No	28d. Dascribe ho	w injury occur	red	
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e Hospital	within 24 hours a To the Funeral [completely filled	edicai (29a. Certifiar 1 Certifying (Check only one)	g Physician: To the be Examinar: On the besi end menner	s of axamination	ge, deeth and/or inv	occurred et the astigation, in m	tima, data and plac y opinion, daeth occ	e, and dua to the ca curred at the time, de	usa(s) and me ta and placa,	annar as sta and dua to	ited. the cause(s)
To the	To the complete of the complet	Me	29b. Signeture and title of centifier	om.n.	0		29c. Lice	3092	7	Od. Dete signe	d (Month, C	ney, Yeer) , 1997
9			30. Nama and address of person v	who complated causa of	of death (Itam 236	(Type, 1	Print)	ver S	pring.	MD	2	0910
	Sta Registr		31. Data filed (Month, Day, Year)	32, Ragi	istrar's Signetura	0.0			01			
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Amend #1, 11/17/97, BMW, Montg. Co Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month November 6, 1997 **Physician** 10:10 PM. Nicholas P. - Smyrnas Smyrnas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) **Examiner** | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kensing | Kens Mariner Health Care of Kensington 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** M 20 F Yrs 577-42-7805 Director Usual Residence of Dacedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or learns 23s or 28s-f show the Medical Examiner must be notified at MD Montgomery Kensington TYPE 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20895 USA 11206 Mitscher Street Funeral 14. Raca - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. 1 ☐ Yes 2K No If Yes, Give Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: py Specify: White 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Hygiene. Oher than Elementery/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Be h and Mental 1 ed bloods P Pericles Smyrnas Chaconas Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Runfola - Niece 11206 Mitscher Street Kensington, MD 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 11/11/97 Washington, Glenwood Cemetery 4 Donation 5 Othar (Specify) 21. Signatura of Funeral Sarvice Licansea 22. Nama and Addrass of Facility Joseph Gawler's Sons 20016 5130 WI Ave. N. W. Washington, D. C. 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Years Normal pressure Hydrocephalus Examiner Due to (or es e consequence of) Examiner physician end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avents resulting in death) Last Due to (or as a consequence of): certificate be axecu Box 68760 Physician/Medical Dua to (or as a consequence of) 68 use (signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1 Yss 2k No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical axaminar? 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 TYas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this funerai 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 5 Pending investigation Attanding 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò To the Hospital c within 24 hours at To the Funeral D completaly filled is 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical 29c. Licensa number 29d. Date signed (Month. Dav. Year) 29b. Signature an D 34032 November 7, 1997 30. Name and a interestise of death (Item 23a) (Type, Print) Jeanne P. Asher, M. D. 3720 Farragot Avenue Kensington, MD 20895 31. Date flied (Month, Day, Year) 32. Registrar's Signature State relia Davidson NOV 13 1997 Registrar

DHMH 16 Rev 6/95

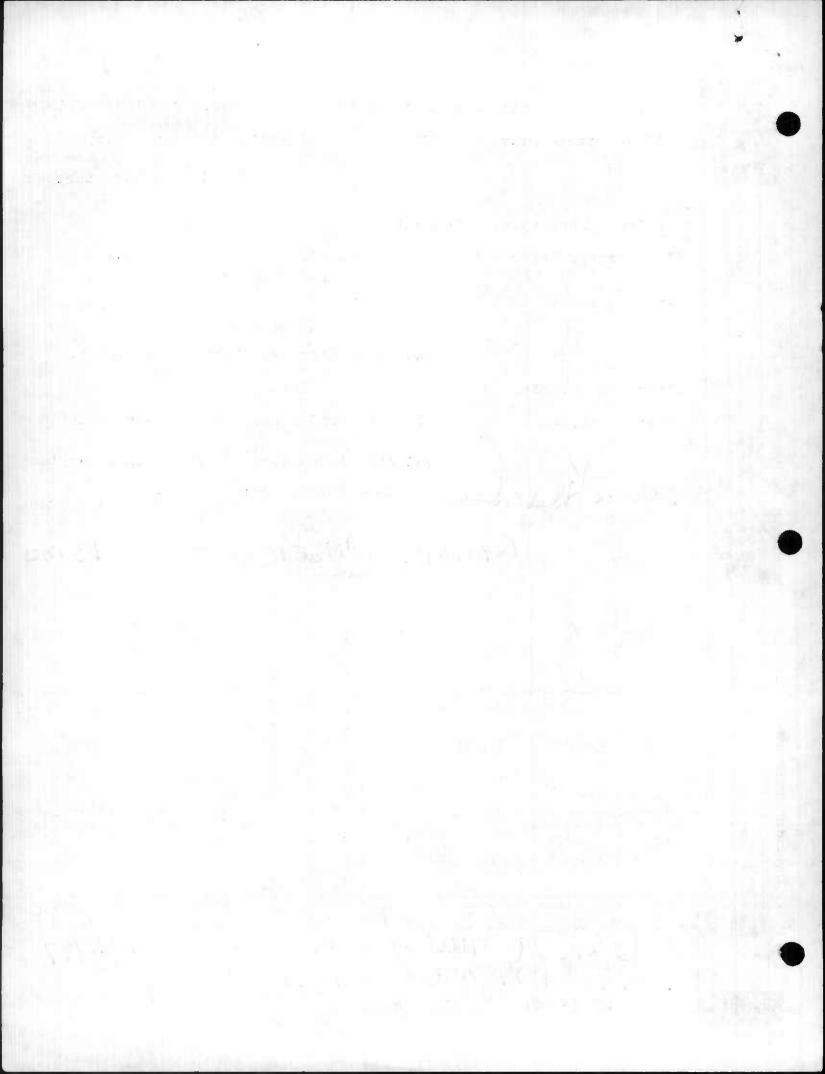


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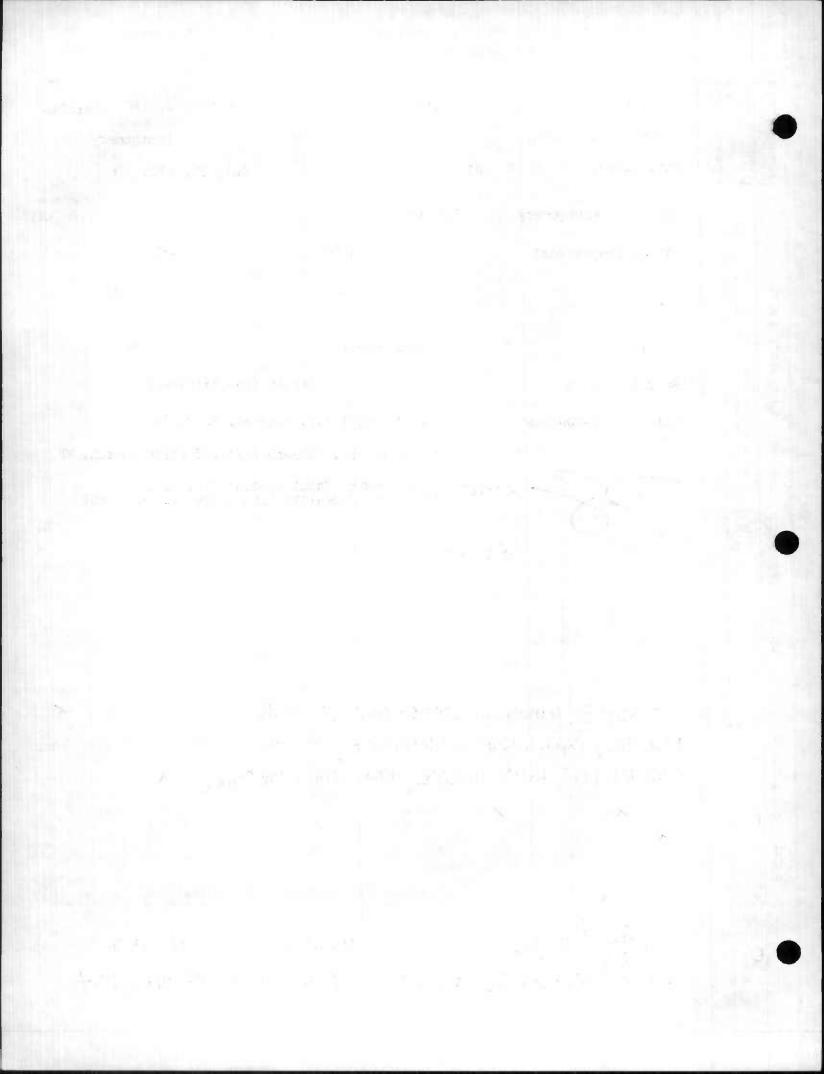
Amend #1,11/19/97/BMW/Montg. Co Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Nov. 1997 Sheeskin Ruth Bortnick Sheskin 6:15PM /Medical 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11420 Strand Drive #010 Rockville Montgomery If Under 24 Hrs. 5. Social Security Number If Under 1 Yeer 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 M 2 VF 579-32-6840 70 Yrs Director Dec 1 1926 | WashingtonDC Usual Residenca of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location "naturel", or items 23a or 28a-f show 10d. Inside City Limits Director Y Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 20852 11420 Strand Drive #010 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedenf Ever in U,S. Armed Forces? 14. Raca - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2√√No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Completed by 3√Vidowed 4 □ Divorced Specify: White The Medical 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) Hygiene. marked other than College (1-4or 5+) U. S. Gov't. 4 Budget Analyst Navy Dept 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Peges 1 and 2 should be nent of Health end Mental Ida Scheer 0 Alexander Bortnick 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health e If Item 27 Is or other tra 7920 Longridge Court Cabin John, MD 20818 Barry Kopit/son 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date NOBuriel 2 Cremation B'nai Israel Cemetery 11/10/ DRemoval from State 97 Oxen Hill, Maryland permit. Pege Department o Important: If any injury or 4 Donation 5 Other (ebiliv) 21. Signature of Funer N.S. 22. Name and Address of Fecility Ives Pearson Funeral Homes Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximete

Approximete Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) CANCER /Medical Examiner Examiner The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai 9 Due to (or es e consequence of): USB BS Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ should be Completed 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to peed completion of cause of deeth? page 2 s this certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) OL 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director: After thi filled in by the funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Netural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 8 Hospital Funeral Medicai 29a, Certifie To the Hosp within 24 hou To the Funer completely fil 👿 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, dete and place, and due fo the cause(s) and manner as stated. Tag Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: on the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Neme and address of person who comple 31. Date filed (Month, State Registrar



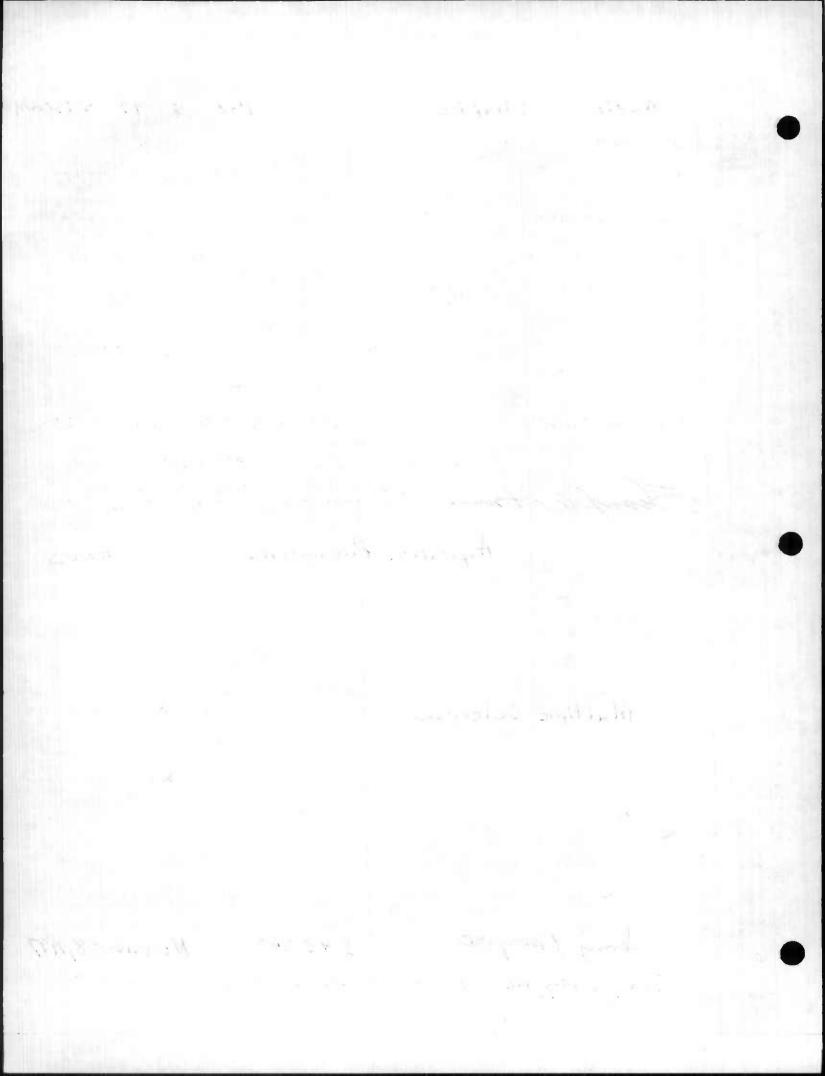
		Decedent's Name (First, It			· maryra		rtificate of	Death		Reg. No. 9 7	3	5732
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/Med Exami		4a. Fecility Neme (If not insti	ution, give stre	et e <i>nd n</i> un	n <i>ber)</i>			4b. City, Town, or L	1	-		4:50am
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Funeral Director		5. Social Security Number 577–48–3529		2 X F	7. Age (In yrs	last birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day July 27	, Year) , 1915	9. Birthr	place (State or Foreign
and and		Usual Residence of Deceder 10a. State 10b. Co			10c. C	ty, Town or Lo	ocation					0d. Inside City Limits
Many	tor	MD Mo	ntgomer	У	Pot	omac						1 ☐ Yes 2 No
with the Marylar a or 28a-f show be not red	Funeral Director	10e. Street and Number 10041 Chape	1 Pond				10f. Zip Code 20854			10g. Citizen of V	Whet Cour	ntry?
eath rs 23	eral	11. Maritel Status		Was Dece	dent Ever in U	IS 13		Henenic Origin? (Sr	acify Ves or No-		e - Americ	en indien,
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland to and Mental Hygiene. This marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examinat must be notified at	by	1 Never Married 2 3	Married	Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 🕱 No e		if Yes, specify Cub	Ilspanic Origin? (Sp en, Mexican, Puerto Specify:	Rican, etc.)		white,	etc.
15-002 72 hours "natural",	eted	15. Dec	dent's Educati	ion om <i>pleted</i>)		16a. Dece	dent's Usual Occur kind of work done	pation during most of work d)	kina	16b. Kind of Bu	usiness/in	dustry
2121 within iene. than	Be Completed	Elementery/Secondary (0-		College (1	-4or 5+)		DO NOT use retired Maker	d)		Own :	Home	
Hygin attended	S	17. Fether's Neme (First, Mic	dle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Surnem	10)	
laryland 212 2 should be filed with end Mental Hygiene. is marked other than aumatic event, the	To B	Samuel Bragm	an					Fannie (unobtai	nable)		
Aar 2 sho end l is me		19a, Informant's Name/Rela						and Number or Ru			State, Zip	Code)
e, Ma 1 and 2: 1 eelth ei 1 m 27 is ther trau		Ellan Baker— 20a. Method of Disposition	Daughte	er	20h		Sorrel A	ve. Poton			01	0.1
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours aft population of Health end Mental Hygiene. Inspectant: If them 27 is marked other than "natural", or any finity or other traumatic event, the Medical Even and the control of the Medical Event and the control of the Medical Event and the control of the Medical Event and the control of the control of the Medical Event and the control of th		1 Burial 2 Cremet 4 Donation 5 Other	r (Specify)	ovai from S		cemetery, crer	natory or other pla-	Gardens 1	Date 1/13/97	Falls	*	
Ball permit Depart Import any inj		21 Signature of Funeral Size	Se Lidensee	-Dar	niel Si	mons		ss of Facility agel Fune ville Pik			D 208	352
Physician / Medical Examined be executed by physician and set the buriel-transit	sal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	a b c	SE	Due to (or as e consec or as a consec	quence of):					Onset and Death
. Box 687 deeth certificate e ettending phys d for use as the	Physician/Medical	resulting in death) Last	d		Due to (d	or es e conseq	uence of):				1	
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cord requir	Completed by	DISEASE,	PARKI	NSO				HRONIC	24a. Was a perfor	an autopsy med?	av co	ere autopsy findings eileble prior to mpletion of cause death?
Vital Rediction: The law certificate hes rector, page 2		OBSTRUCTI 25. Was cese referred to me	VE LI	ING	DISEA	rSE, 11	HERSTITI.	AL LUNG				Yes 2 No
Of VIta Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No	Hosp	oital:	patient 2	ER/Outpatier	nt 3 DOA Oth	26. Place of Deal	me 5□ Resid		er (Snecit	v)
On Of ding Phys h. After this funeral d		27. Manner of Death 1 ⊠Netural 5 □ Pe		8e. Dete o		28b. Time of Injury	1		28d. Describe h			<u> </u>
	ertification:	2 Accident Inv	estigation	28e. Place o	of injury - At h g, etc. (Speci	ome, farm, str		Yes 2□No	28f. Location (S City or Tow		er or Rure	l Route Number,
Hospital 24 hours Funeral refy filled	edical Co	29a. Certifier (Check only one)	fying Phyelcia cat Examiner:	n: To the to On the bar	sis of exemine	wledge, death	occurred at the tirvestigation, in my o	ne, dete end plece, pinion, deeth occur	end due to the cred et the time, c	euse(s) and me lete end plece, a	enner es si and due to	ated. the cause(s)
To the within 2 To the comple	Me	296. Signature and title of co	tiller -				29c. Licens	e number	2	29d. Date signer	d (Month,	Dey, Year)
10		M	more	2			02	6571		11/11/	97	
10		30. Name and address of per	11ZU	SIMI	of death (Iter	30 D!	ELRAY	AVE. BE	THESON	A, MD	208	14
Sta Regist	-	31. Date filed (Month, Day, Y	14 1997	32. Re	wistrer's Signi	dson-Ran	delle.					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle								Date of De Month			Veer	3. Tin	ne of Deeth
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camine	-	4a. Facility Name (If not institution,	, give street and	number)			4	b. City, Town,	or Location	on of Deet	h 4c.	. County o	of Death		
_		GOLDEN OAKS NUR				1614		AUREL					GEO		
eral tor		5. Social Security Number 577-42-3939 Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F		. last birthday Yrs.	Months	Days	if Under 24 Hours	Aln.	Date of Bir Month, Da EC 15			9. Birthpi Count PENNS		ANIA
		10a. State 10b. County		10c. C	ity, Town or L	Location							10	Od. Insid	de City Limits
	to	MARYLAND MONTGO	MERY	SII	VER SP	PRING								1 🗆	Yes 2₩ No
	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of W	hat Coun	try?	
	a D	15038 SHAMROCK	RIDGE R	OAD		209	06			1	INTT	ED S'	TATES	S	
	ner	11. Marital Status	12. Was D	ecedent Ever in I	U,S. 13.			spenic Origin n, Mexican, P	(Specify			14. Raca	- America	an India	in,
	þ	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 TYYe	S 2 NOTO	REAN	1 ☐ Yes		Specify:	Del to Trice	iii, 6 (0.)			WHI		
	ted	15. Decadent' (Specify only highest	s Education		16a. Dece	edant's Usua	ai Occupa	ation furing most of	working		16b. Ki	ind of Bus	siness/Ind	lustry	
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	Be	17. Father's Neme (First, Middle, L	ast)					18. Mother's	Name (Fi	rst, Middle	, Maiden	Sumame	9)		
	L O	SAMUEL SHAPIRO						IDA LA	TINSK	(I					
		19a. Informant's Name/Ralationsh						and Number o							
		SYLVIA SHAPIRO/	WIFE	1.00				RIDGE							20906
		20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation	3 Removal fro		Placa of Disp cametery, cre	emetory or o	me or other place	e)		ate	20c. Lo	ocation - (City or To	wn, Stel	te
once.		4 □ Donation 5 □ Other (Sp		MI	LEBA				11/9	9/97	ADEL:	PHI,	MARY	YLAN	ID
ouce.		21. Signature of Funeral Sarvice L	icensee	,		22. Name an		s of Facility OLDBER	G MEN	fOR TA	L CH	APEL	S. IN	VC.	
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** NOVEMBER 12, 1997 MARY E. SHELTON 04:05 P.M. /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | June 11, 19 36 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiaca (State or Foreign Country) **Funeral** Virginia 61 Yrs. Director 231-46-6326 Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location or 28s-f show 10d. Insida City Limits the Medical Examiner must be notified at 1 ☐ ¥as 2 ☐ No Director Prince Georges Capitol Heights 10f. Zlp Coda 10e. Street and Number 10g. Citizen of What Country? 6902 Drylog Street 20743 Norma 23a U.S.A. Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 Navar Married 2 Married 1 ☐ Yas 2 ☒ No If Yas, Giva ò 1 ☐ Yas 2 No Specify: Specify: Black þ lf Yas, Giva Yaar or Datas: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementery/Secondary (0-12) Collega (1-4or 5+) P.G. Schools Teachers Aide 12th 17. Fathar'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be James C. Arthur Nina Pettiford 2 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 2 0 7 4 3 19a. Informant's Name/Raiationship (Type, Print) permit. Pages 1 and 2: Department of Health at Important: If them 27 is any injury or other tracents. Melvin Shelton (Husband) 6902 Drylog Street, Capitol Heights, MD 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Arlington Nat'l Cem. 11/20/97 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funaral Sarvice bicensage 22. Nama and Addrass of Facility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Entar the disaasa, or shock, or haan failura. List complications that caused tha daath. Do not entar the mode of dying, such es cardiec or respiretory errest, only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediata Causa (Final METASTATIC CARCINOID UNKNOWN disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated asserts.) and Dua to (or as a consequence of) attending physician Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequence of) ed by the Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detact 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings aveilable prior to completion of cause of death? has 1 Yas 2 □ No 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 🖾 Natural 5 Panding To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Invastigation 1 Yas 2 No 2 Accident 6 ☐ Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, ferm, street, factory, offica building, atc. (Specify) 4 Homicida 29a. Cartifiar 1 🖸 Certifying Phyeician: To the best of my knowledge, death occurred at tha tima, dete end plece, and due to the cause(s) and mannar as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) IN 01031565 NOVEMBER 12, 1997 Owwe 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 89 MDG/1050 W PERIMETER RD SUITE C1-7 JANICE RUSNAK, LT COL, USAF, MC ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar 31. Data filed (Month, Day, Year)

NOV 14 1997

32. Ragistrar's Signatura

Julia Davidson-Randalle

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72 hours after

Pages 1 and 2 s ment of Health an

or Attending Physician: The law requires that the death certificate be executed

certificate

this

After

death.

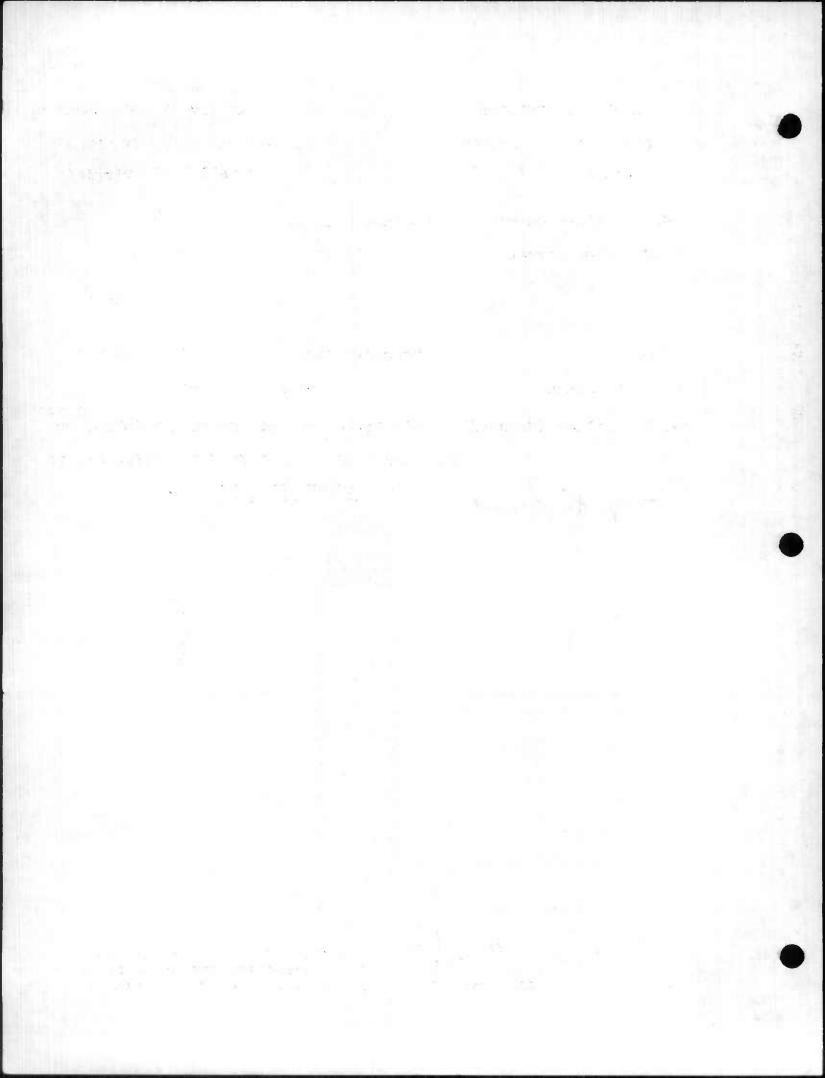
Box 68760.

Division of Vital Records, P.O.

Maryland 21215-0020

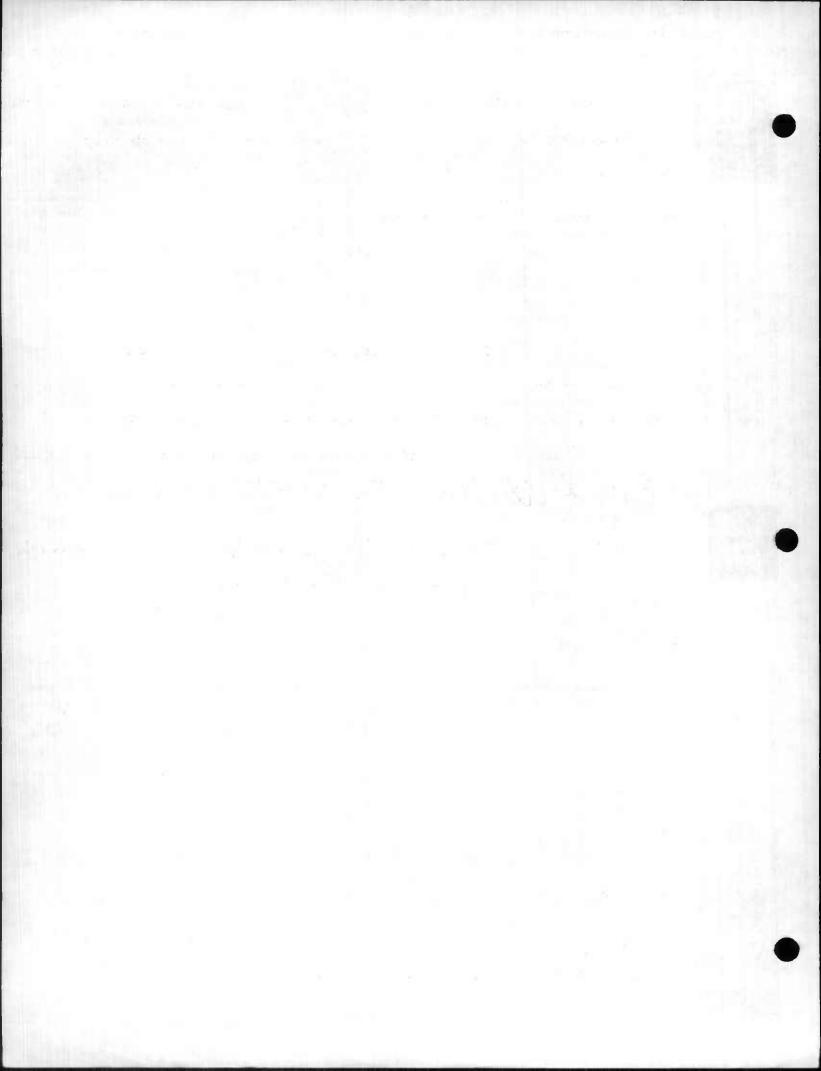
Baltimore,

Quino



State of Maryland / Department of Health and Mental Hygiene 7 35735

						Ce	runca	le oi	Death			Reg. No.		
Physici /Medic		1. Decedent'a Name (First, Mi			EPHE	ERO					Date of Do Month OVEN	Day	Year 1997	3. Time of Death
Examin	er	4a. Fecility Name (If not institu Suburban			im <i>ber)</i>				4b. City, Tow Beth		on of Dea		of Death Egomer	y
Funeral Director		5. Social Security Number 058-05-6001	6. Se	x ⊐м 2Хо́F	7. Age (In) 8	rs. last birthdey) Yrs.	If Und Months	or 1 Year Days	if Under 2 Hours	4 Hrs. 8. Min. Ma	Date of Bi (Month, Di LTCN	rth 17, 1916		ce (State or Foreign YOCK
show	or	Usuel Residence of Decedent 10a. State 10b. Cou New York Ot	nty ieens		10c.	City, Town or Lo							100	d. Inalde City Limits
a or 28a Lbe notif	Direct	10e. Street end Number 59–10 Queens				WOOdsi	10f. Z	ip Code				10g. Citizen of United		
al', or items 23a or 28a-f show Examiner must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 N 3 Widowed 4 Divorce	arried	12. Was Dec	orces? 2 No ive			edent of H	lispenic Origi en, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No	o- 14. Rac	ca - Americar ck, White, etc	n Indien, c.
ene. then "natura he Medical E	Completed	15. Deced (Specify only hig Elementery/Secondary (0-12	hest gred	le completed)	1-4or 5+)				eation during most of	of working		16b. Kind of B		stry
Mental Hygiene. erked other ther atic event, the M	To Be Co	17. Fether's Name (First, Midd Ferdinand		as	1		Secre	tary	18. Mother			Lawye , Maiden Sumen Lvery		
tment of Haalth and tant: If Item 27 is m jury or other traum		19e. Informent's Name/Relatic Francis W. She 20e. Method of Disposition 1X8 Buriel 2 Cremetic 4 Donation 5 Other	epher	emoval from	State	er) 2706 b. Place of Dispo cometery, cres ate of I	Wel esition (Me matory or Heave	ler leme of other pleasen Ce	Road, metery	Silve	r Spi	cing, Ma 20c. Location Silver	ryland City or Town	20906
Depar impor any ir		Signatur, of Funeral Servi Servi	DI	Ville	elli	2 R	app 1	Tuner st Ave				A. ng, Mary		20910
ysician and publical aminer and properties as the privat-transit	Physician/Medical Examiner	tmmediete Cause (Final disease or condition resulting In deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Inderlying Ceuse (Disease or injury that initiated events resulting In deeth) Lest	{		Jama Duer Duer Duer	o (or es a consec	Lov Jaso c	ver mla						oproximate interval Batween conset and Death Sweeky
ed by the atte datached for	ysicia	Pert II. Other significant cond	itions cor	ntributing to d	eath but not	resulting in the u	nderiying	cause giv	en in Part I.		23b. Did tobacco use contribute			
has been sign ye 2 should be	Completed by Ph										24e. Wes	Yes 2 No s en autopsy ormed? Yes 2 No	avalla	e eutopsy findings able prior to oletion of cause ath?
his certificate has al director, page 2	Certification: To Be	3 Suicide 6 Cou	ding stigation		28b. Time o Injury	M 1			28d.	5 Res	idence 6 Oth	red	Route Number,	
Within 24 hours effer To the Funeral Directory Completely filled in by	edical Certi	29a. Certifier 1 X Cartif	ring Phy	Physician: To the best of my knowledge, deeth occurred et the time, date end pleca xamtner: On the basis of examination and/or investigation, in my opinion, death occurred.							28f. Location (Street end Number of City or Town, State) eca, end due to the cause(s) and menne courred at the time, date and placa, end			ed. ne ceuse(s)
To the	Mec	29b. Signature end title of certification	2	Q.	ner stated.		29	D2	e number 789	1		29d. Dete signe November	d (Month, De	oy, Year) 1997
	te	30. Name and eddress of person RAJVANSM 31. Date filed (Month, NOV	IN	0 (2)	se of death (I		Print) L	me:	#409	Roo	knl	le mo	2085	2.



BALTIMORE, MARYLAND 21215-0020	s after death. Page 6 may be retained by the hospital or attending physician.	by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
8	after d	by the

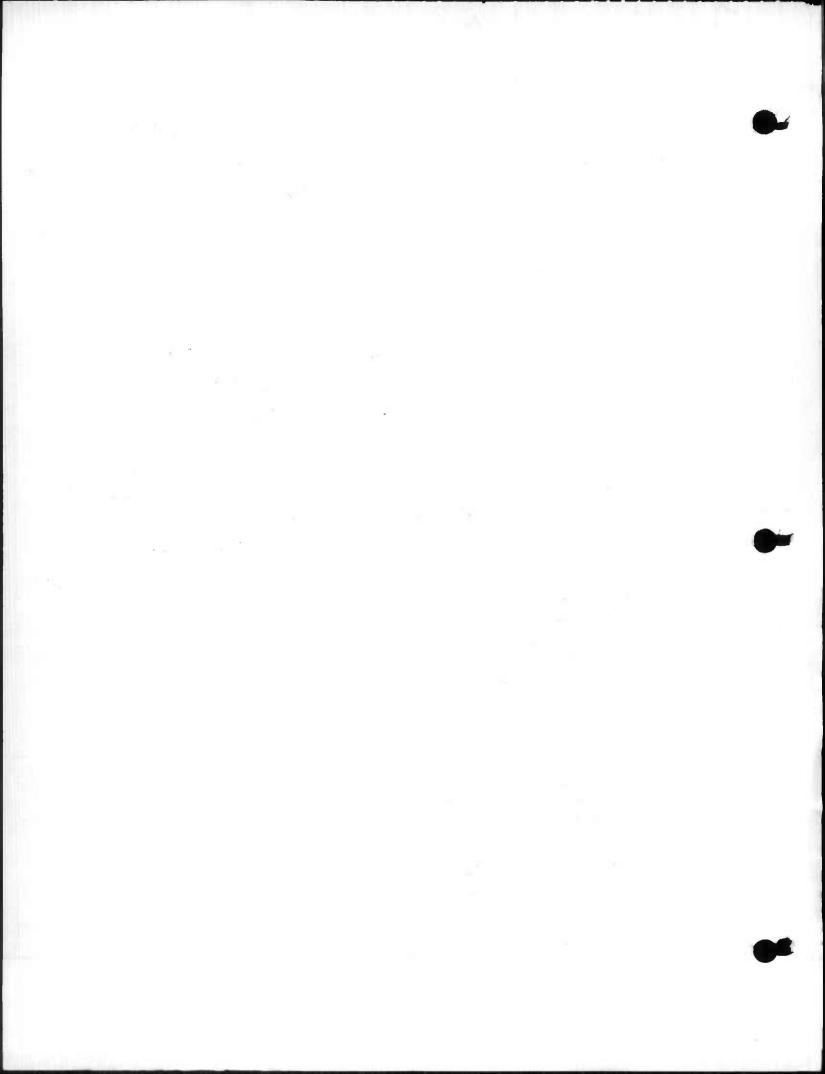
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examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	Ξ
19.	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	8
e funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	2
r death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a their death. Page 6 may be retained by the hosp	2

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

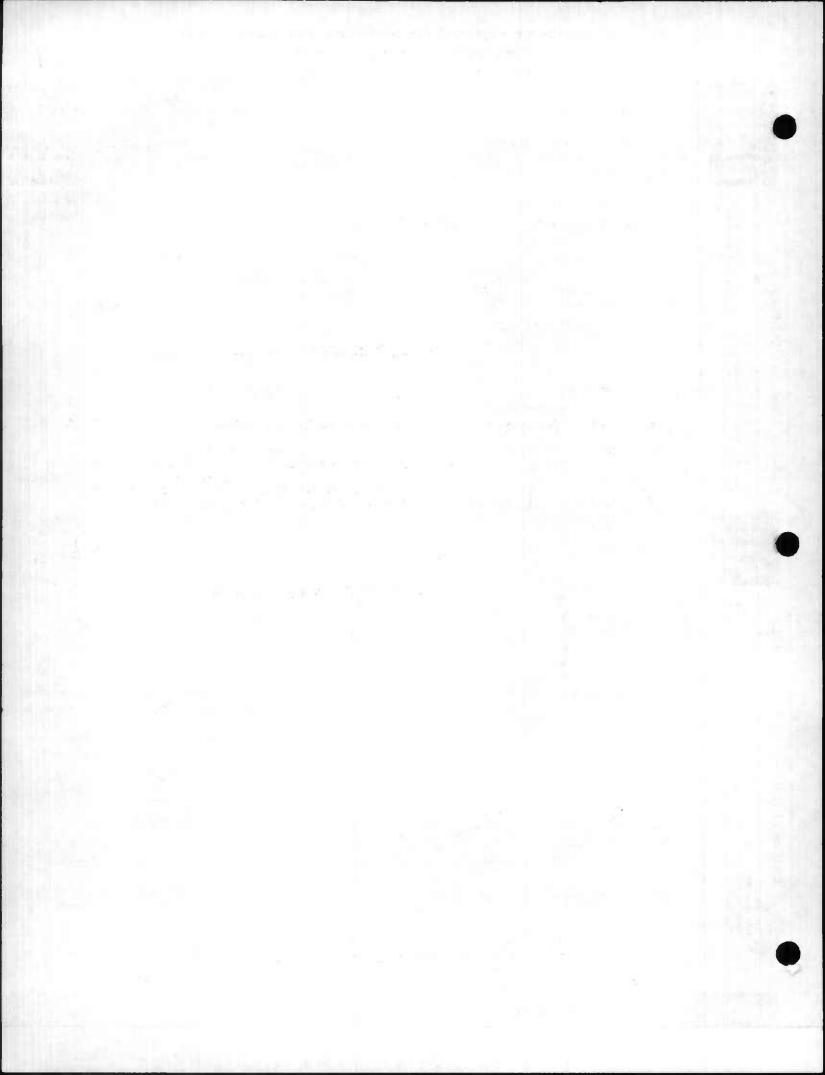
	REGISTRAR			С	ERTIF	CATE C	F DEATH	R	IEG. NO.			
	1. DECEDENT'S NAME (First, Midd	tle, Last)		SCH	ON	FEL	D	2. DATE OF E	DAY		YEAR	3. TIME OF DEATN
	4. SOCIAL SECURITY NUMBER	<u> </u>	SEX 6	AGE (In vrs. la		IF UNDER 1 YE		NOV.		199		3:30p M
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5	RESIDENCE OF DECEDE	ENT										
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FUNERAL	10e. STREET AND NUMBER						10f. ZIP CODE					WNAT COUNTRY?
Ä	6121 Montrose		We December 6	2152 01110 11	24452	40 11110	20852				US	
BY FU	1 Never Married 2 Marrie 3 Wildowed 4 Divorced	led	P. WAS DECEDENT E FORCES? 1 2 IF YES, GIVE WAR	OR DATES	NO	If yes	DECENDENT OF HISPAI , specify Cuben, Maxice YES 2 NO Specif	n, Puerto Ricen	secify Yea o	or No—	14. RACE Black Speci	E — American Indian, k, White, atc. #y: White
TED	15. DECEDEN (Specify only high	IT'S EDUCAT	ION ripleted)	(0	Bive kind of w	USUAL OCCUP	ATION most of working	16b. KIN	D OF BUSI	NESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	2	College (1-4 or 5 +)		Write	,			New	spap	er	
S	17. FATHER'S NAME (First, Middle,		5-14				18. MOTNER'S NA			iumame)		
BE	Jacob D. 19a. INFORMANT'S NAME (Type/Pr	Schor	niera	10	DAILING OF	ADDRESS /Sta	Esther			Canan Tim	Codel	
유	Una Schonfeld		9		5815	Edson	Lane #204	Rockv	rille	, Md	20)852
	20a METHOD OF DISPOSITION 1 Burial 2 Cremation 3 4 Donation 8 Other (Spec		t from Stata			FDISPOSITION MOTTAL	Gardens 1	DATE /14/9	20c. LOC/ 7 Oln/	ey,	City or To	wn, State
	21. SIGNATURE OF FUNERAL SER	NVICE LICEN	SEX /			Edw 109	e and address of fa ard Sagel 1 Rockvill	Funera Le Pike	1 Di	rect kvil	ion le,	Md. 20852
	23. PART I. Enter the disees	ses, or com	npiicetions thet c	eused the d	eeth. Do n	ot enter the	mode of dying, auc	h as cardlec	or reapire	atory arr	rest,	Approximata
	IMMEDIATE CAUSE (Finei	renore. Lia	1			. 0						Interval Between Onset and Death
	disease or condition resulting in daeth)	a	DUE TO (OI	TEKA	L TS	SYIRA	TION PI	VEUM	INO	TIS		1 DAY
z	Sequentially list conditions,	b	MULTI	-1N	FAI	RCT	DEM	ENT	TIA			
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING		DUE TO (OF	R AS A CONSE	OUENCE OF):						
ĬĘ	CAUSE (Disease or Injury that initieted events resulting in death) LAST	1 "	DUE TO (OF	R AS A CONSE	OUENCE OF):						
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	DIABE	etes	MEL	-LI TU	5,	TYPE	11		YES 2	NO		COMPLETION DF CAUSE DF DEATH?
PHYSICIAN: M	DID TOBACCO USE (CONTRIB	SUTE TO CAUS	SE OF DEA	ATH YE	s 🗆 NO	UNCERTAIL					1 YES 2 NO
Z	25. WAS CASE REFERRED TO MED EXAMINER?			26. PLA	CE OF DEAT	N (Check only						
XSI	1 TYES 2 NO		OSPITAL:	R/Outpetlant	DOA 🗆	4 Nursing	Nome 5 - Rasidenca	6 Other (Spe	ecify)			
ВУ РН	27. MANNER OF DEATN 1 Natural 5 Pendi	ing tigation	26s. DATE OF IN. (Month, Day.		26b. TIME INJI	JRY	INJURY AT WORK? YES 2 NO	28d. DESCRIE	BE HOW IN.	JURY OC	CURED	
요	3 Suicide 6 Could	100	28e. PLACE OF II building, etc	NJURY — At he . (Specify)	ome, farm, s	treet, factory, o	office	28t. LOCATION	N (Street an wn, State)	d Number	or Rural F	loute Number,
LE	29a. CERTIFIER 1 CERTIFYIN	IG PHYSICIAI	N: To the best of my	knowledge, dr	ath occurre	d at the time	data and place, and dua	to the cause(s)	and mean	var na etet	ad	
COMPLET												e) and manner as stated.
BE C	29h. SIGNATURE AND TITLE OF C	BATTIFIER	ATT	en din	Pla.	164m	29c. LICENSE NUI	ABER CALL		29d. DAT	E SIGNED	(Month, Day, Year)
	30. NAME AND ADDRESS OF PER	SON MINO	MPLETED CAUSE	OF DEATH #]	7 × 44	018	084		PIV.	OVER	MBER 11,1997
	D.D. PATO	EL 1	10 612	MOT	tros		Pocku	lly V	402	08	12	,
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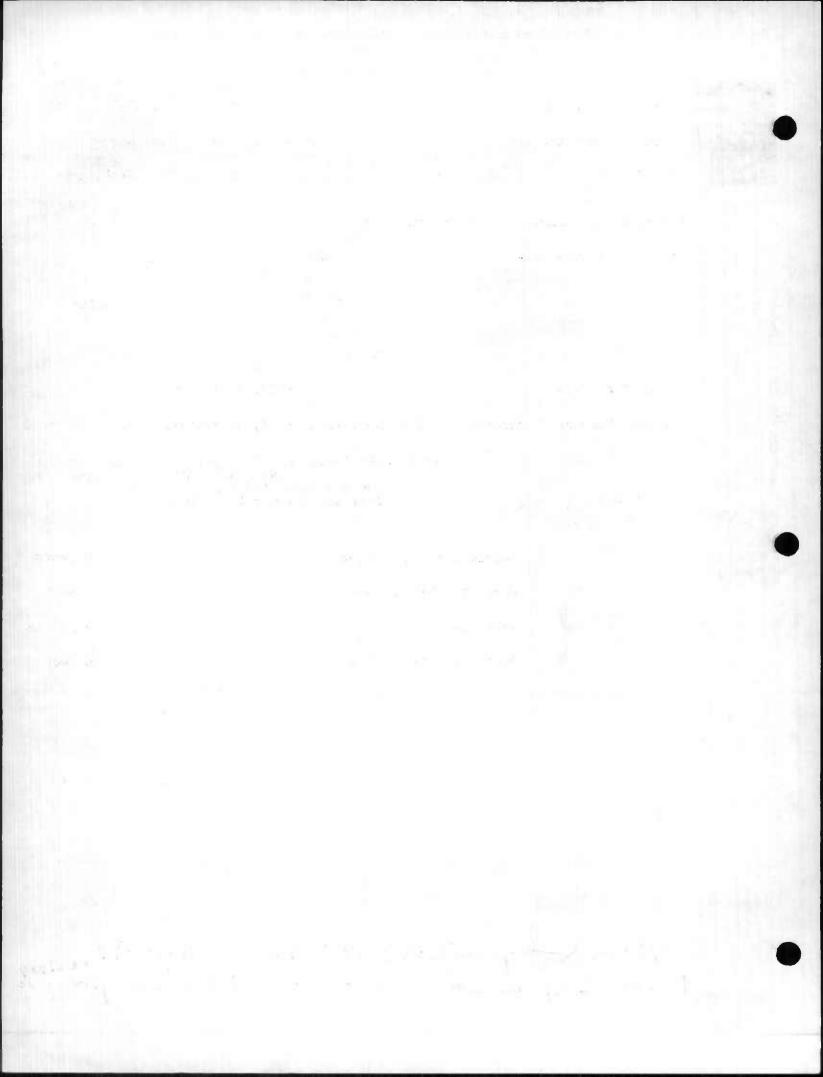
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CKallill	iei	Montgomer	ry Conor	al Hoen	ital				Olney			Monts		17
uneral		5. Social Security Nu		Sex HOSP		s. lest birthday)	If Under 1	1 Year	If Under 24 Hrs	8. Dete of	Birth			·
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% w			10b. County		10c. C	ity, Town or Lo	cation						10	0d. Inside City L
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3 Time of Leath rb, 1997 **Physician** Grace F. Speake November 3:19 AM /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1126 Cresthaven Drive Silver Spring Montgomery If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number If Undar 1 Yaar 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Devs Months 1 ☐ M 2 🛣 F 218-80-4514 90 Yrs Director Jan. 8, 1907 Washington, D.C Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Maxical Examinar must be not fact 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1126 Cresthaven Drive 20903 USA Funeral 12. Was Decedant Evar In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritel Status 14. Race - Amarican Indian, Black, Whita, atc. 72 hours efter 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 XNo Specify. þ 3 ₩ Widowed 4 Divorcad White Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent'e Education (Specify only highast grada complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "n any Injury or other traumatic event. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Be William P. Foley 0 Christian Juneau 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Margaret Haering / Daughter 3300 Greencastle Road, Burtonsville, Maryland 20866 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata Dete 1 ☐ Burial 2 TCramation 3 ☐ Ramovel from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Fort Lincoln Crematory 11/12/97 Brentwood, Maryland 22. Nama and Address of FecilityHines-Rinaldi Funeral Home 21. Signature of Funeral Service Licenses 11800 New Hampshire Avenue Donnell Silver Spring, Maryland 20904 23a. Pert 1. Entar tha disaase, or complications that causad the daath. Do not antar tha mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. Est only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immedieta Causa (Final disease or condition resulting In daath) /Medical Ischemic Heart Disease 30 years Examiner Dua to (or as a consequence of) Examiner Pneumonia Aspiration 1 week certificeta be executed buniel-transit Sequantielly list conditions, if eny, leading to Immadiate causa. Entar Undarlying Causa (Disaase or Injury thet Initiated avants rasulting In daath) Last pue Dua to (or as a consequence of): physician e the buriel-Box 68760, Azotemia 4 months Physician/Medical Dua to (or as e consequance of): 88 attending p Peripheral Neuropathy 50 years 980 Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? the à 1 Yes 2 No 3 Probably 4 Unknown signed t by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death? Completed peen pege 2 s has 1 ☐ Yas 2 ☑ No certificete 1 ☐ Yas 2 No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 🖾 Rasidanca 6 ☐ Other (Specify) To 1☐Yas 2☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Dete of Injury (Month, Day Year) 27. Mannar of Deeth 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after deeth. To the Funeral Director: After the completally filled in by the funera 28d. Dascribe how Injury occurred Certification: After 5 Pending invastigation 1 DiNaturel 1 Yes 2 No 2 ☐ Accident 6 Could not be datermined 3 Sulcida 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At home, farm, straat, factory, office building, alc. (Spacify) 4 Homicide 29a. Certiflar Medical 1 🕱 Certifying Phyaician: To the best of my knowledga, death occurred et the time, dete and place, end due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature end titla of cartifiar 29c. Licensa number 29d. Dete signed (Month, Day, Year) 0 Der end addrass of person who complated ause of death (Itam 23a) (Type, Print) \$811 colesville Rd Silver Spring 10 Impere 32. Ragis mn 32. Registar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Deta of Deeth **Physician** Month Prem Lata Sood November 1997 12:00 PM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 10203 Nolan Drive Rockville Montgomery 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) July 31, 1 9. Birthplece (State or Foreign Country) India 7. Age (In yrs. lest birthday) **Funeral** 1□M 2\ F Days Hours 052-84-3675 61 Yrs. Director Usuel Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Rockville 10e, Street end Number 10f. Zip Code 10g. Citizan of What Country? items 23a 10203 Nolan Drive 20850 Canada death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yaer or Detes: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Black, White, etc. should be filed within 72 hours after on Mentel Hygiena.

merked other than "natural", or iter 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify by Specify: 3 ₩idowed 4 Divorced Indian Completed Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Felhar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Be Charan Nehra Dass Basanti 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) -69 nt of Health a : If Item 27 is or other tra Ramesh Sood (son) 10203 Nolan Drive, Rockville, Maryland 20850 20b. Place of Disposition (Neme of cemetary, cremetary or other place) 20c. Location - City or Town, Steta 20e. Mathod of Disposition Dala 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit, Page Depertment of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 11-12-97 Beltsville, Maryland 22. Nema and Address of Fecility Rapp Funeral Services, P.A. 23a. Pert1. Enter the diseesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest,

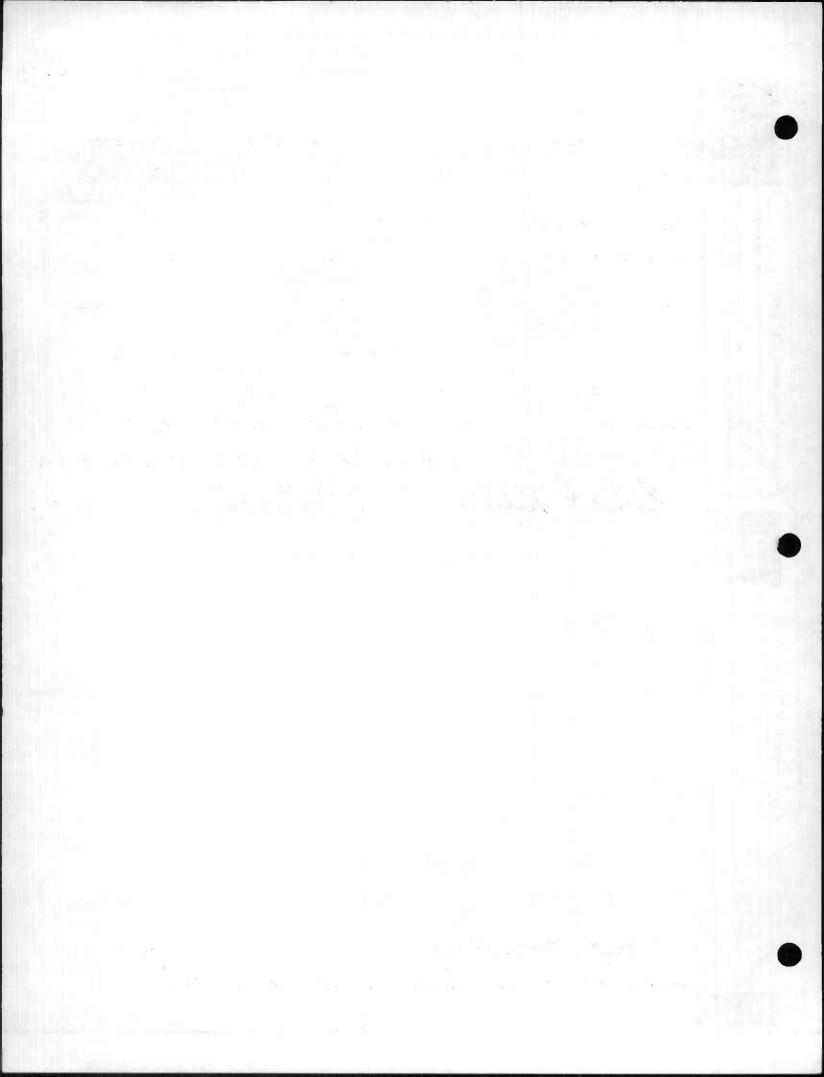
Approximately a such as cardiec or respiretory errest,

Approximately a such as cardiec or respiretory errest, 20910 Approximate Interval Between Onset end Deeth **Physiclan** /Medical Immediate Cause (Finel Adenocarcinoma, Unknown Primary 2 months disease or condition resulting in deeth) Examiner Due to (or es e consequence ol) Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initieted events rasulting in deeth) Lasl Due to (or es e consequence of): Box 68760. Physician/Medical Dua to (or as e consequence ol) 88 ed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown eta hes been signed page 2 should be da Records. by 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes an eutopsy performed? 1 ☐ Yas 2 X No 1 ☐ Yes 2 ☐ No certificeta Vital or Attending Physician: director. Be 25. Was case refarred to medical 28. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Nasidence 8 Other (Specify) To 1 Yes 2 No Division of this funeral 27. Menner of Deeth Certification: 28e. Deta of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accidant efter death the 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 ☐ Homicide pelli 24 hours Hospital 1 Certifying Phyalcian: To the best of my knowledga, death occurred et the time, date end plece, end due to the ceuse(s) end menner as steled.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner stated. edical 29a, Certifier within 24 ho To the Fune completely fi (Check only one) To the 29b. Signeture end lilia of certilier 29c. Licensa number 29d. Dete signed (Month, Day, Year) D18912 November 10, 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Staal, M.D. 1221 Mercantile Lane, Largo, Maryland 31. Date filed (Month NOV 32. Registrar's Signature

Fulia Davidson-Randese State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month November 13 Physician GREER SLACUM CHARLES 1997 7:45 pm /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge 911 Race St. 6. Sex. 2□ F 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) March 30 1915 Mary Land 7. Age (In vrs. last birthdey) 9. Birthplace (Stete or Foreign **Funeral** Months Days Houre 218-14-1610 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. tnside City Limits arked other than "natural", or leans 23e or 28e-f show witc event, the Medical Examiner must be notified at Cambridge Dorchester TEXes 2□No Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21613 911 Race St. U.S.A. Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever In U,S. Armed Forces? 14. Rsce - American Indian, 11. Maritel Stetus Black, White, etc. 1 Never Married 27 Married 1 Yes 27 If Yes, Give Year or Detes: 1 Yes ZINO Specify: Specify: white À 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) "right of way" state, highway dept. appraiser 17. Fsther's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Carter Elizabeth Major Colonna Slacum. 19a. Informant's Name/Retetionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) $911\,$ Race St., Cambridge MD $21613\,$ Louise T. Slacum - wife 20b. Placa of Disposition (Neme of commetery, crematory or other place)

Dorchester Memorial Park 11-16-97 Cambridge, Maryland 20a. Method of Disposition borial 2 Cremetion 3 Removal from Stete 4 Donation 5 □ Other (Specify) 21. Signature of Foneral Service Licenses 22. Name end Address of Facility
Thomas Funeral Home PA 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. 700 Locust St., Cambridge MD 21613 Approximate Interval Between Onset and Death Physician Gunshot Wound to head-self inflicted /Medical Immediate Cause (Finel min disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting In death) Last Due to (or as a consequence ot): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NUSSION ð 24b. Were autopsy findings sysilable prior to Completed 24a. Wes an sutopsy completion of cause of death? 1 ☐ Yes 2 Z No 1 ☐ Yes 2 ☐ €o 25. Was case referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

the death certificate be execu Records, P.O. Box 68760. Division of Vital death.

Limbs boun Snewn

Department of Health and Mental Hygis reportant: If Item 27 is marked other

Medical

State

Registrar

signed by the ettending physicien and d be detached for use as the burlel-transit sate hes been signated bage 2 should b this certificate hes the funeral After To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu

(Check only

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

Addical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piaca, and due to the cause(s) end manner stated.

29b. Signature and title of certifie

29c, License number

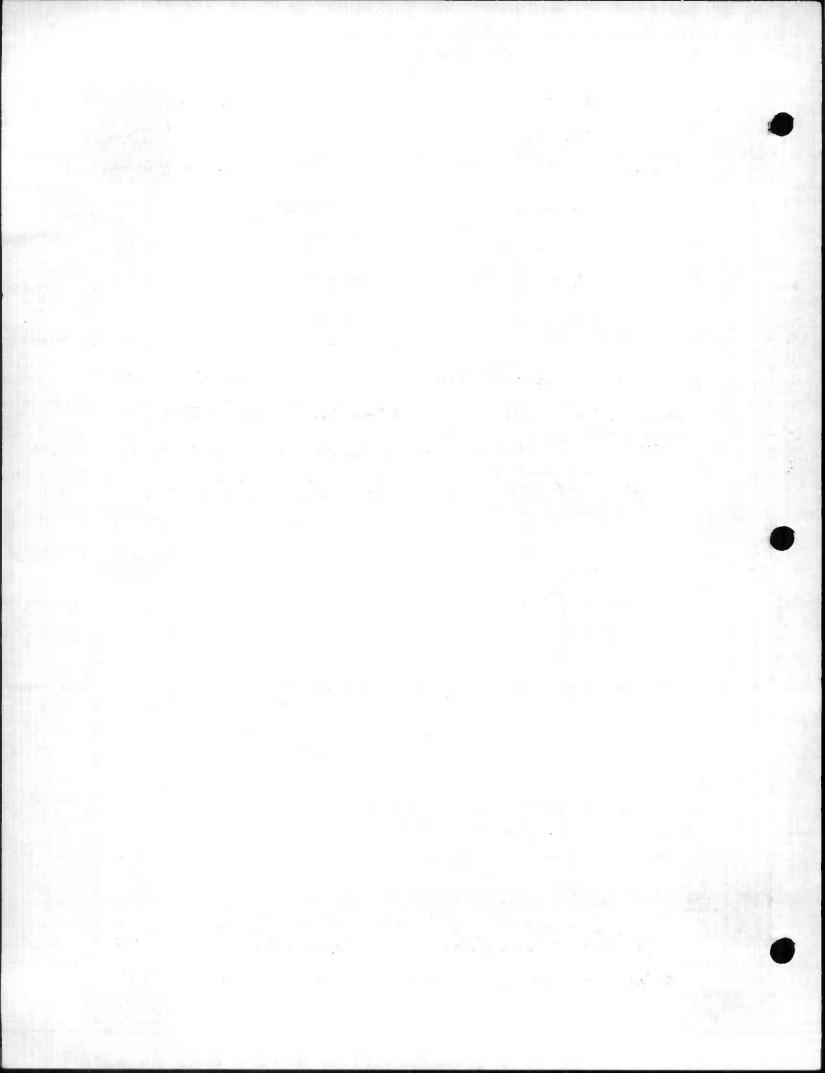
29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Faclules ms 302 Collise 302-Calling

31. Dete filed (Month, Dey, Year)

32. Registrar's Signature Tube Davidson Re

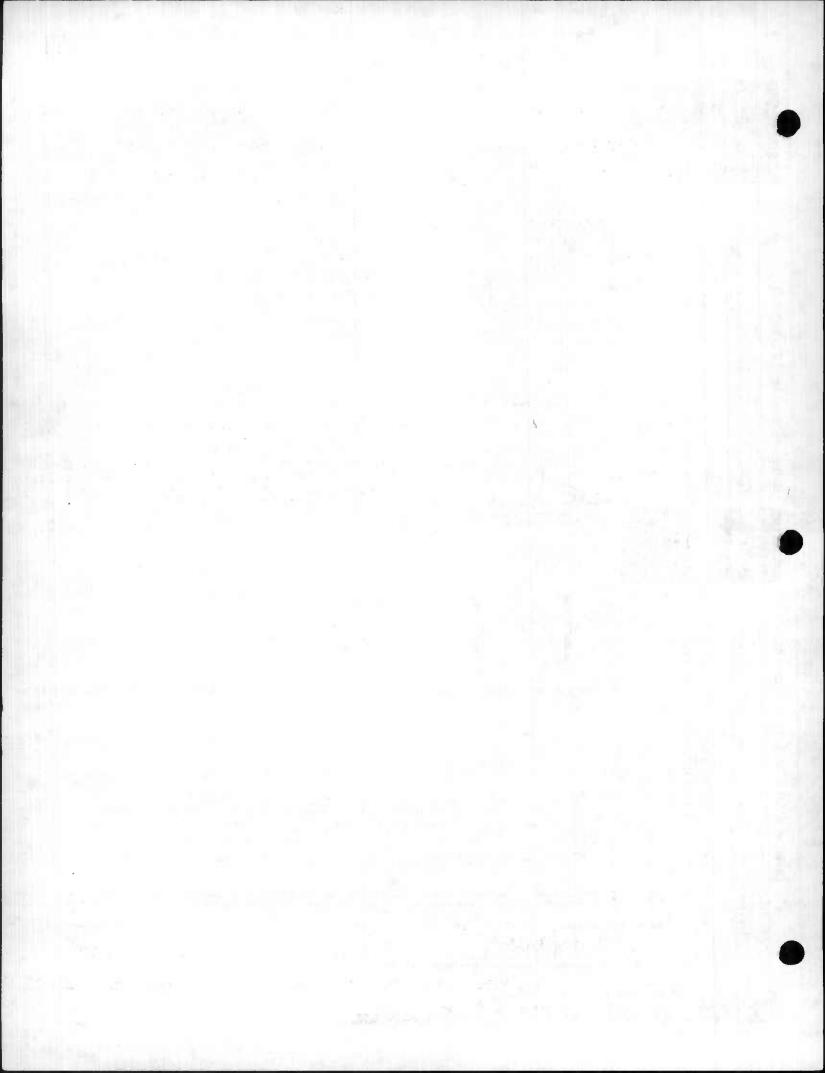


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State of Maryland / Department of Health and Mental Hygien	ie 3/	33	1

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yeer Veronica M. Taylor November 6, 1997 /Medical 8:50AM 4e. Fecllity Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gaithersburg 9704 Inaugural Way Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** 1□M 2♥F Months Days Hours Yrs. Director 107-01-1323 79 Feb. 5, 1918 New York Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Germantown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 deeth with items 23a 20505 Afternoon Lane Funeral 20874 United States 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 X No Specify: by Specify: 3 ☐ Widowed 4 ☑ Divorcad White Completed 15. Decadent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elamantary/Secondary (0-12) Collage (1-4or 5+) Homemaker 8 Own Home 7 is marked other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be Joseph Piekielniak 2 Agnes Robak 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: if item 27 is m any Injury or other traum Carolyn P. Leffler/Daughter 20505 Afternoon Lane, Germantown, MD 20874 20b. Place of Disposition (Neme of cemetery, cremetory or other place)
November 10, 1997 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Sarvica Licans 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 • M00803Rockville, Maryland 300 West Montgomery Avenue and 20850-2805 M00803 Rockville, Maryland 20850-28
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** fmmediete Cause (Final disease or condition resulting in deeth) /Medical a Aspiration Pneumonia Days **Examiner** Due to (or as e consequance of): Examiner End Stage Dementia Years The law requires that the death certificate be executed lcian and burief-tran Sequentially list conditions, if any, laeding to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the Due to (or es a consequence of): 98 158 0 signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, ð 24b. Were autopsy findings available prior to completion of cause of death? pinous Completed 24a. Wes an autopsy performed? peed page 2 s has certificate 1 ☐ Yes 2 No 1 ☐ Yes 250 Xlo of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director; to Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5. Rasidenca 6 Other (Specify) ASS 18ted Hospitel: 1 ☐ tnpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending Investigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homleide 29a, Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) D31391 November 7, 1997 30. Name and eddress of person who implated cause of death (Itam 23a) (Type, Print) Suhair H. Abulfarag, M.D. 481 N. Frederick Avenue, #230, Gaithersburg, MD 20879 31. Date filed (Month, Day, Yeer) 32. Registrer's Signature State Julia Davidsen NOV10 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey 9, 1997 Ruth **Physician** reichler. 9:17pm /Medical 4e. Fecility Neme (If not Institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** LANHAM PRINCE GEORGES 5. Sociel Security Number Community Hospital 6. Sex Hospital 7. Age (In yrs. lest birthdey) If Under 1 Year if Under 24 Hrs.

Montha Deys Hours Min. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1□M 20F 072-07-7006 Yrs. 80 OCT. 20,1917 NEW YORK Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PRINCE GEORGES LANHAM 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6807 WOODSTREAM DR. 20706 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ā No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Rece - American Indien, Bleck, White, etc. 11. Maritei Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: þ 3X Widowed 4 □ Divorced Specify. WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 CONVENTION CO-ORDINATOR HOTELS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be THEODORE I. YARNELL STELLA BENNETT 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) THOMAS E. TREICHLER/SON SAME AS MCULT 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetlon 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 11/11/97 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signeture of Funerei Service Licensee 22. Name end Address of Fecility COMMERCE MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complication of let caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Bradycardia + Heart Block tum mediate obable Myoca-dial Infaretion Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medicai Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Goux, 1 Yss 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? Left Ventricolar 24a. Wes an autopsy periormed? Hype-trophy, 1 Yea 2 €No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 -Naturel 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 | Homicide 29a, Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted. 29b. Signature apostitle of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

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Director: After this certificata has been signed by the ettanding physician end

Baltimore, Maryland 21215-0020

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Box 68760.

P.O.

Division of Vital Records,

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month 10, 1997 Vincent Carl Tolino 10:59AM November /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Montgomery General Hospital 01ney Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F Yrs. 206-09-0921 80 Sept. 10,1917 Pennsylvania Usuat Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 Narrows Lane 20906 United States Funerai 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: by Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Precious Metal Expert US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rafael Tolino Rosaria Tolino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Tolino / Wife 1905 Narrows Lane, Silver Spring, Maryland 20b. Place of Disposition (Name of cemetery, cremetery or other place) Nov. 14, 1997 20a. Method of Disposition 20c. Location - City or Town, State XXBuriel 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Gate of Heaven Cemetery 21. Signeture of Funeral Service Licenses 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/ M00348 Rockville, Inc., 300 W. Montgomery Ave., Rockville, Maryland 20850-2805 Julla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final CONCESTIVE disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 20 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29a. Certifier Medicai Signature and title of ce 29c. License number 29d. Date signed (Month, Dey, Year) olvey ms 20832

State Registrar

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, it is Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or ther any Injury or other traumatic event, it a Medical Example.

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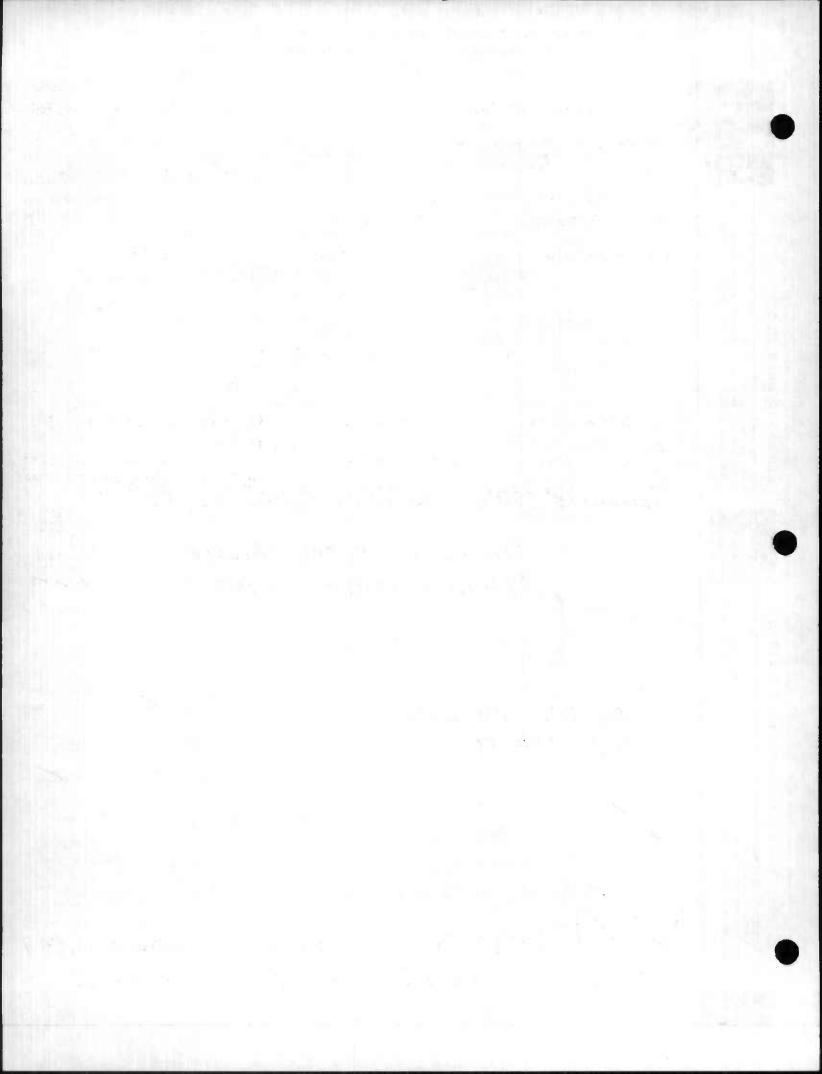
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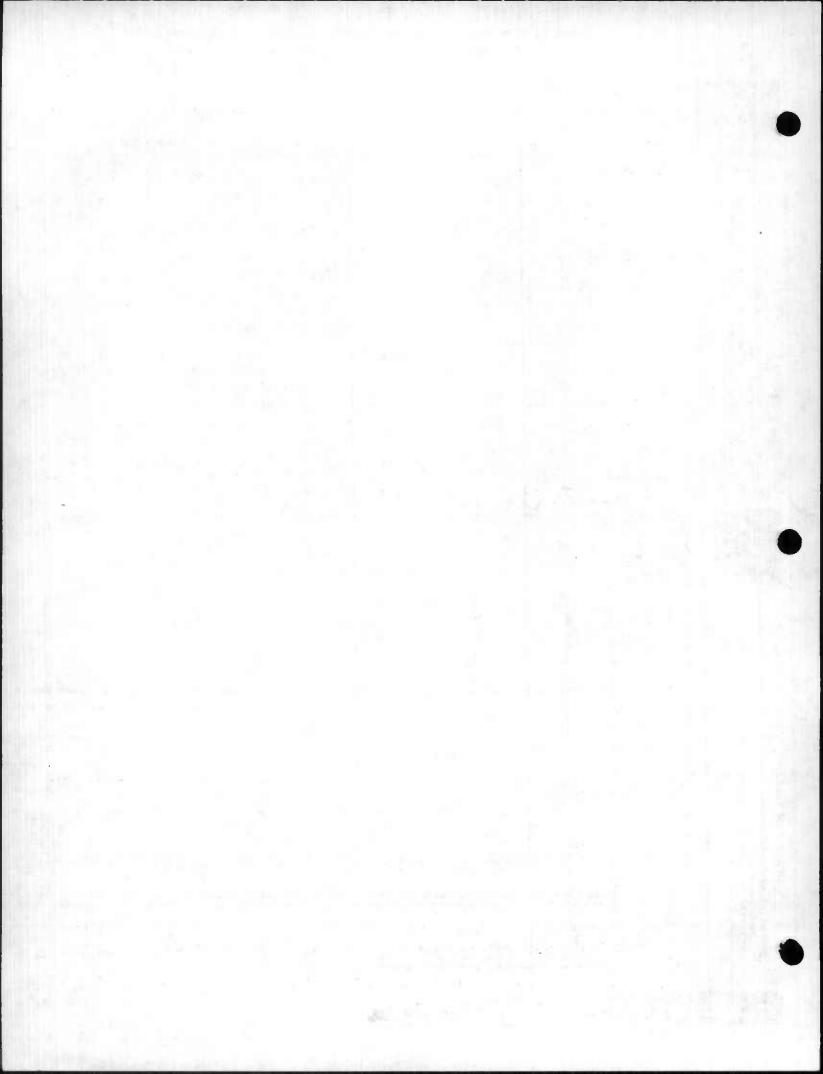
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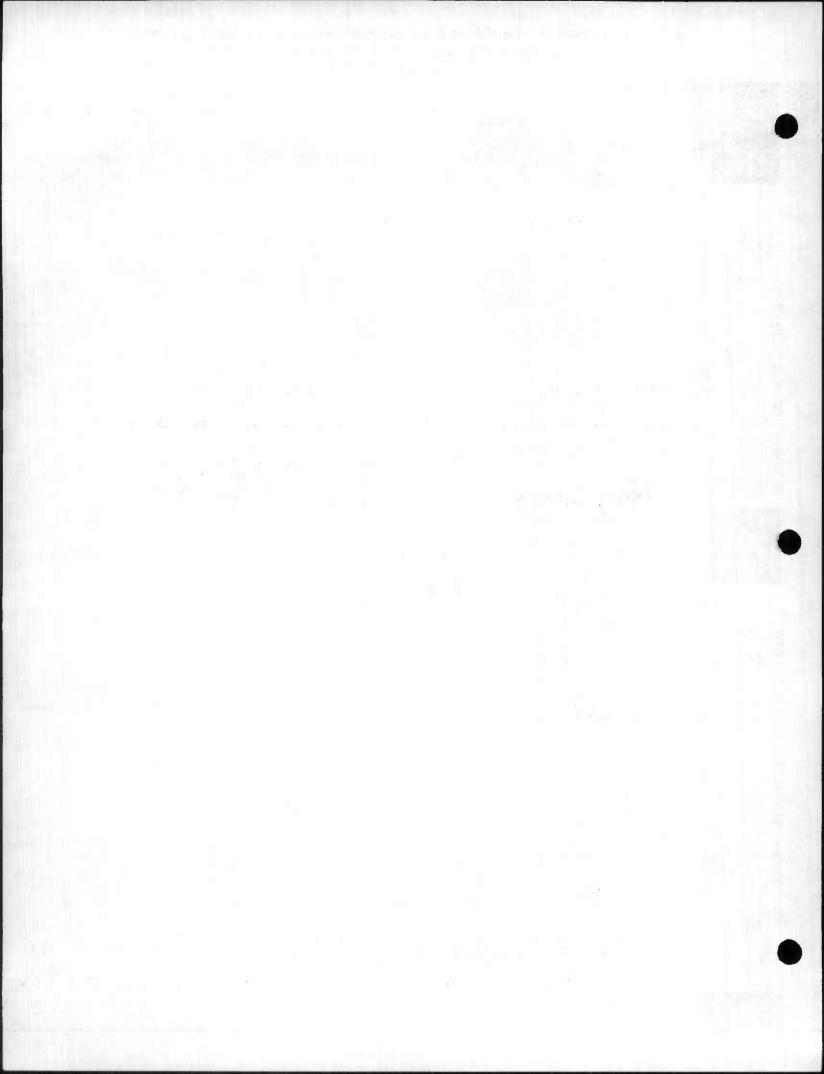
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State of Maryland / Department of Health and Mental Hygiene

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o pes	o Be	Demetrios Griva								-/		
7 is marked other than traumatic event, the M	2	19a. Informent's Name/Relationship			19h Mailina Add	race /Stract		sia Gri Rural Route Numbe		State Zin Code		
E		Barbara Bistis 20a. Method of Disposition	(daugnter)					Arlingt		22204 City or Town, State		
= -		1 Buriai 2 ☐ Cremation 3			e of Disposition etery, cremetory							
Important: If any injury o once.	-	4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie		Gate	of Heav	ven Ce	metery	11/12/97	Silver	Spring, MD		
Important: I any injury o once.		1. Signature of Funeral Service Life	tives.		Home,	Inc.		iversity 20901				
-1		23a. Part1. Enter the disaasa, or co shock, or heart feilure. List or	omplications that caused ily one cause on each lin	the death. (Do not entar tha	node of dyin	ng, such as cardia	ac or respiratory en	rest,	Approximete Interval Between		
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P 88		30. Name end address of person who	o completed cause of de				toun 1	0 4	R	, 20		



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/Medic	al	As Fastin Name (Mark)				r will				ember	3, 19	997	12:45 A	
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manal	-	5. Social Sacurity Number	6. S		Aga (in vr	s. last birthday)	If Undar 1 Year	AD1	ngdon	a of Birth		ford	non /Ctata or Formi	
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or 28	Director	10e. Straat and Number					10f. Zip Coda			10g.	Citizan of V	What Count	ry?	
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or oth		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Crama	ion 3 🗆	Ramovai from Ste	20b.	Place of Dispos cematary, cran	sition (Nema of natory or other pla	ca)	Data	200	. Location -	City or Tow	m, Stata	
lury		4 Donation 5 □Oth	(Specify)		lingtor	Nationa	al Cem	. 11-7-	-97 A	lingt	on, V	irginia	
important: If item 27 is merked other than "n any injury or other traumatic event, ins Mad once.		21. Signature of Funeral Se	KN	Land	St	# HO	Nama and Addra Sward K. 317 Cokes	McComa sbury 1	as III 1 Rd Ab	inador	. MD	2100	9	
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uneral Dir	edical C	29a. Certifiar (Check only one) 1 ★ Cert	ertifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end place, a edical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred and manner stated.								e, and dua to the causa(s) and menner a urred et tha tima, data and place, and di			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Howard Wittich 3:55 PM Warren 1997 November 5 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Mariner Health of Forest Hill Forest Hill Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Deys Yrs. Director 272-22-3574 June 18, 1923 Ohio Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Harford Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 836 Lynn Lee Drive 21001 12. Wes Decedent Ever in U,S.
Armed Forces?
1 by Yes 2 no if Yes, Give Yeer or Dates: 1941–1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Specify: White 1 Yes ₽ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 11 U.S. Government Model Maker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Frederick August Wittich Myrtle Louise Beaumier 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Marian J. Wittich - Wife 836 Lynn Lee Drive, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 11-8-1997 Aldino, Maryland 21. Signature of Funeral Service License 22. Neme end Address of Facility Howard K. McComas III Funeral Home P.A. e, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximete Interval Between Onset and Death terminal chronic obstructive pulmonery Immediate Ceuse (Finel diseese or condition resulting in deeth) Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24e. Was an autopsy performed? Were autopsy findings evailable prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 28. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpalient 2 ER/Outpatient 3 DOA 27. Menner of Death Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Vatural 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

/Medical Examiner bunal-transit and P.O. Box 68760, physician 8 the for u been signed by t should be detact Records. certificate has Division of Vital this After To the Hospital or Attending death. I Director: / efter within 24 hours of To the Funeral I Medical

the Maryland

death

Baltimore, Maryland 21215-0020

iges 1 end 2 should be filed within tof Health and Mental Hygiene.

If Item 27 is marked other than

Pages nent of h

permit. Page Department of Important: If any Injury or

Physician

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

completely 24

State

Registrar

29b. Signature end title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Dete signed (Month, Day, Year)

23e) (Type, Print) Aberdeen

31. Dete filed (Month, Day, Year)

4 Homicide

29a. Certifier

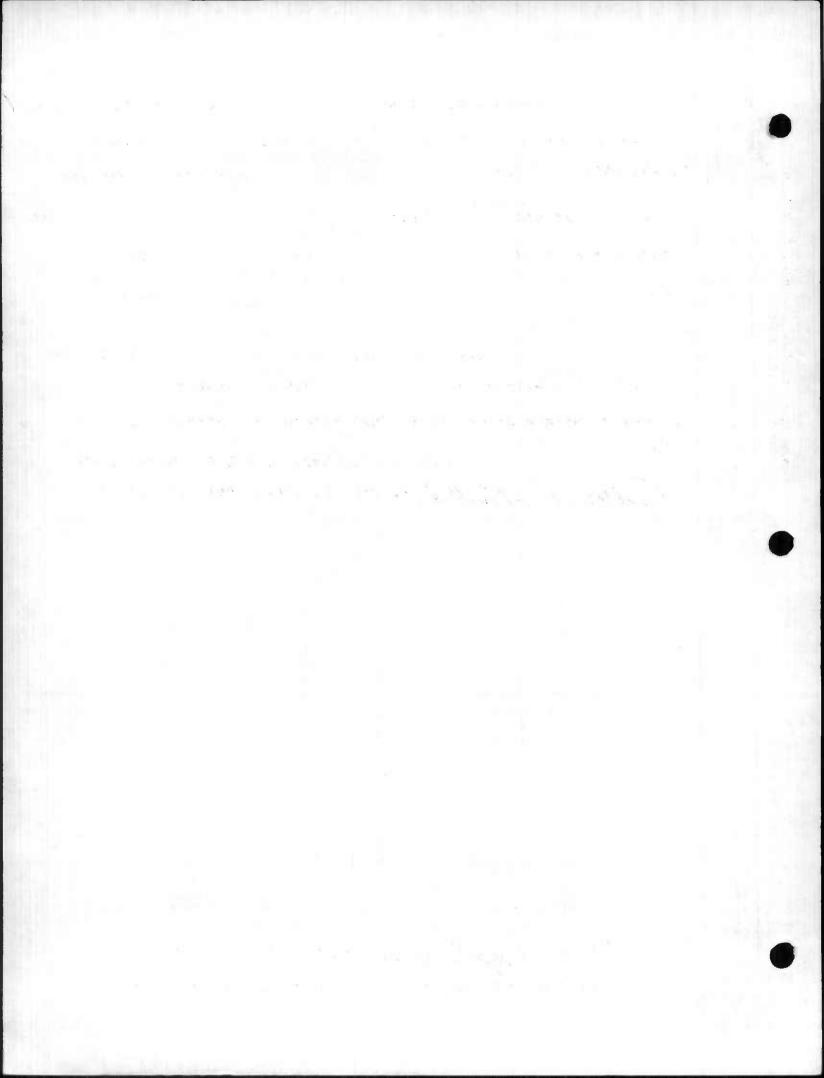
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State of Maryland / Department of Health and Mental Hygiene

5748 Certificate of Death 1. Decedent's Nama (First, Middle, Last, 2. Date of Death 3. Tima of Death 10, 1997 Month **Physician** Frances A. Wilson 09:38 am November /Medical 4a. Facility Nama (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Yaar if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sax 8. Data of Birth (Month, Dey, Year) Birthpiaca (State or Foreign Country) **Funeral** 10 M 27 5 Months Days 215-34-9981 Yrs. 65 Director Wilson 5/29/32 Maryland Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itama 23a or 28a-f ahow traumatic avent, the Medical Examiner must be notified at MD Harford Street 1 ☐ Yas 2 ☐ No Director V 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with known to physician: Frances altimore, Maryland 21215-0020 3539 Wilson Road 21154 IISA Funeral death 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican indian, Black, White, etc. oe filed within 72 hours after all Hygiene. DCDSever Married 2 Married 1 ☐ Yas 2 ☐ You If Yes, Give Year or Dates: 1 ☐ Yes 3 No Specify: swhyi te by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Eiemantary/Secondary (0-12) Coilege (1-4or 5+) Utility Company 4 yrs Customer Relations permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othy any Injury or other traumatic avent, SIGE. 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) S. Raymond Wilson Sr. Fanny Schuster 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Samuel R. Wilson Jr.-brother 3525 Wilson Rd., Street, MD 21154 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stata ¥3 Buriai 2 □ Cramation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highland Cemetery 11/13/97 Street, MD 22. Name and Addrass of Facility ef Funeral Service Lice Harkins F.H.Inc., Delta, PA 17314 ov Nam Exter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting In death) a Massive pulmonary embolus days Examiner Due to (or as a consequence of): Examiner certificata be executed -tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): the burial P.O. Box 68760. physician Physician/Medical Due to (or as a consequence of): USB as attending for use as been signed by the a should be detached Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, by Completed 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of causa of death? has page 2 YOYes 2 No 1 DYes 2 No certificate Division of Vital 25. Was case rafarred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerai 27. Manner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Attending Aftar 5 Pending investigation 1X Natural death. 1 Yes 2 No To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide edicai 29a. Certifier 1 Certifying Phyalolan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D30206 RON 11/10/97 auga 30 30. Name and address of person who comp se of daath (Item 23a) (Type, Print) Steven A. Pearlman, GBMC 6701 N Charles St; Baltimore MD 21204 32/ Pegistrat's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Veer Merlin Williams, C. OV. 1997 330 A 8 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** John Deaton Nursing & Rehab Center Baltimore 7. Age (In yrs. lest birthdey)
75 Yrs.

If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer)

Jan 5, 1922 5. Sociel Security Number **Funeral** 9. Birthplece (Stete or Foreign 100M 20 F 214-12-7326 Maryland Director Usuel Residence of Decedent the Maryland 10a Stete 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MD Montgomery Takoma Park Director 1 Nes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? ò 20912 U.S.A. or Herns 23a 7620 Maple Avenue 12. Was Decedent Ever In U,S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 43-46 13. Was Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specity Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, Whita, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: À Black Specify: 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) School 6th Bus Driver marked other 17. Fethar's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Heelth and Mental Hy
Important: If Item 27 Is marked other 18. Mother's Neme (First, Middle, Melden Sumema) Be Hallie L. Smith Stanley M. Williams 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code, 1090 Good Hope Dr., Silver Spring, 20905 Brenda Kosh (Daughter) 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cramatory or other placa) 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 11/13/97 Sandy Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) Ash Memorial Cem. 21. Signature of Funeral Service Licens 22. Name end Address of Facility
SNOWDEN FUNERAL HOME,
ROCKVILLE, MD 20850 23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart is lura. List only one cause on each line. Approximata Intervei Between Onset end Deeth Physician Immediata Cause (Finel disease or condition resulting in death) /Medical 3 weeks Examiner Examiner Atherosclamba Cardiovascular The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last physician end s the buriel-tran Dua to (or es e consaquence of) P.O. Box 68760. Physician/Medical Due to (or es e consequenca of) 88 ed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown signed t Records, by 24b. Wara autopsy findings aveileble prior to completion of cause of death? Completed 24a. Was en autopsy performed? certificate has page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Wes case raferred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After Division 5 Pending Investigation 1 Matural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledga, daeth occurred at tha time, deta and place, and due to tha causa(s) end mannar as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and menner stated. 29e. Certifiar Medical 29th Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

32) State

Registrar

ME SHULAM 1. NOV 13 1997

MD

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

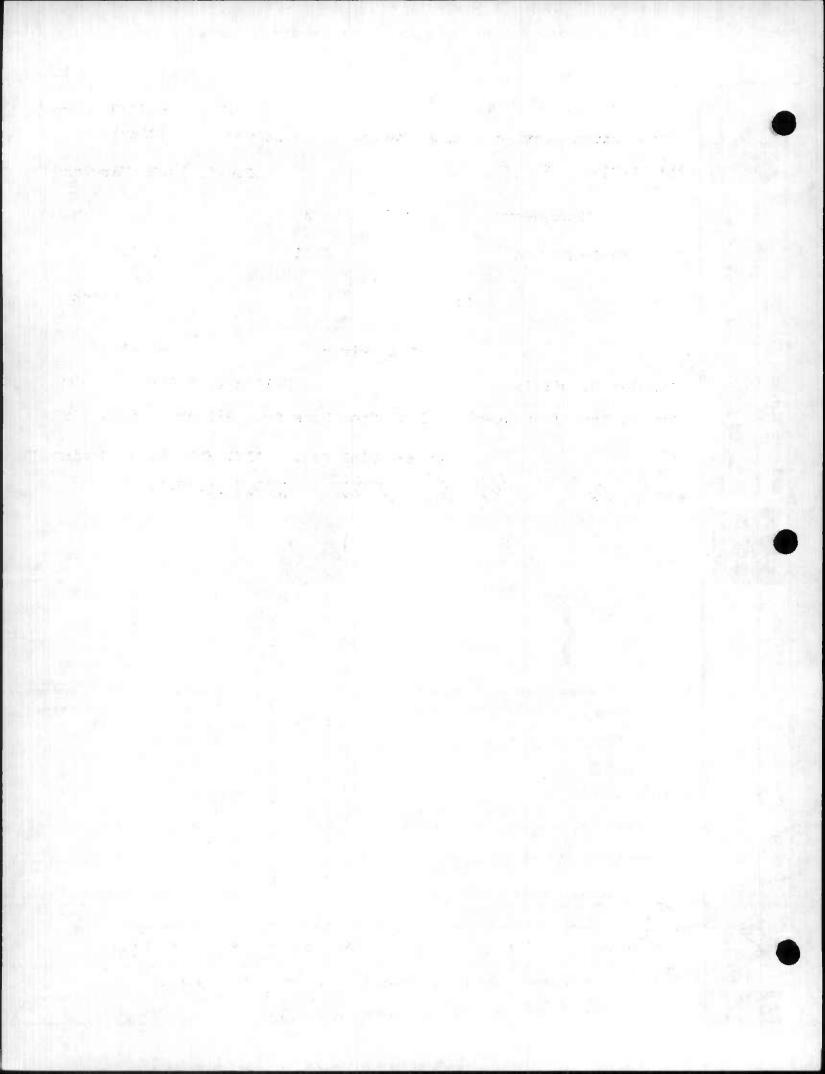
32. Registrer's Signature

Julia Davidson-Randelle

D38675

BALT MD

21230



State of Maryland / Department of Health and Mental Hygiene 9 7 3 5 7 5 0

Certificate of Death

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State of Maryland / Department of Health and Mental Hygiene 97 35751

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WARNICK, St. NOVEMBER 08 Month 2015 P **Physician** JOSEPH Anthony 1997 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva straat end number 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 79 Yrs 577-20-6130 Director February 21, 1918 Maryland Usuai Residenca of Dacedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f ahow traumatic avent, the Modical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12118 Selfridge Road United States 20906 death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yas 2 □ No Il Yes, Give Year or Datas: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 X Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Gas Station 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Lest) and Mental I is marked or Not Available Not Available 19b. Mailing Address (Street end Number or Ruret Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Haaith and Important: If item 27 Is n Wanda L. Sheldon/Daughter 12118 Selfridge Road, Silver Spring, Maryland ce of Disposition (Neme of Date 20c. Location - City or Town, State 20906 20b. Place of Disposition (Name of cametery, cremetory or other place November 12, 1997 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Parklawn Memorial Park Rockville, Maryland rece Lice 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 pipelt, in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one country on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final 2 DAYS a CARDIOGENIC disease or condition rasulting in death) Examiner Due to (or es a consequence of) Examiner PNEUHONIA 2 DAYS RESPIRATORY FAILURE DUE TO ician and burial-trans Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be exec ACUTE MYOCARDIAL INFARCTION 2 DAYS physician s the buria Box 68760 Physician/Medicai Dua to (or as a consaquence of) 50 980 Po 23b. Did tobacco usa contribute to the cause of death? P.O. Part II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. the the detached signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown by Division of Vital Records. 24b. Were autopsy findings available prior to completion of causa of deeth? 24e. Wes an eutopsy Completed has page 2 1 Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1º 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) luneral 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: if or Attanding P after death. After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Couid not be detarmined 3 ☐ Sulcida 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - Al home, farm, street, factory, office building, etc. (Specify) 6 4 - Homicide Hospital of the Hours a 24 hours • Funeral Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

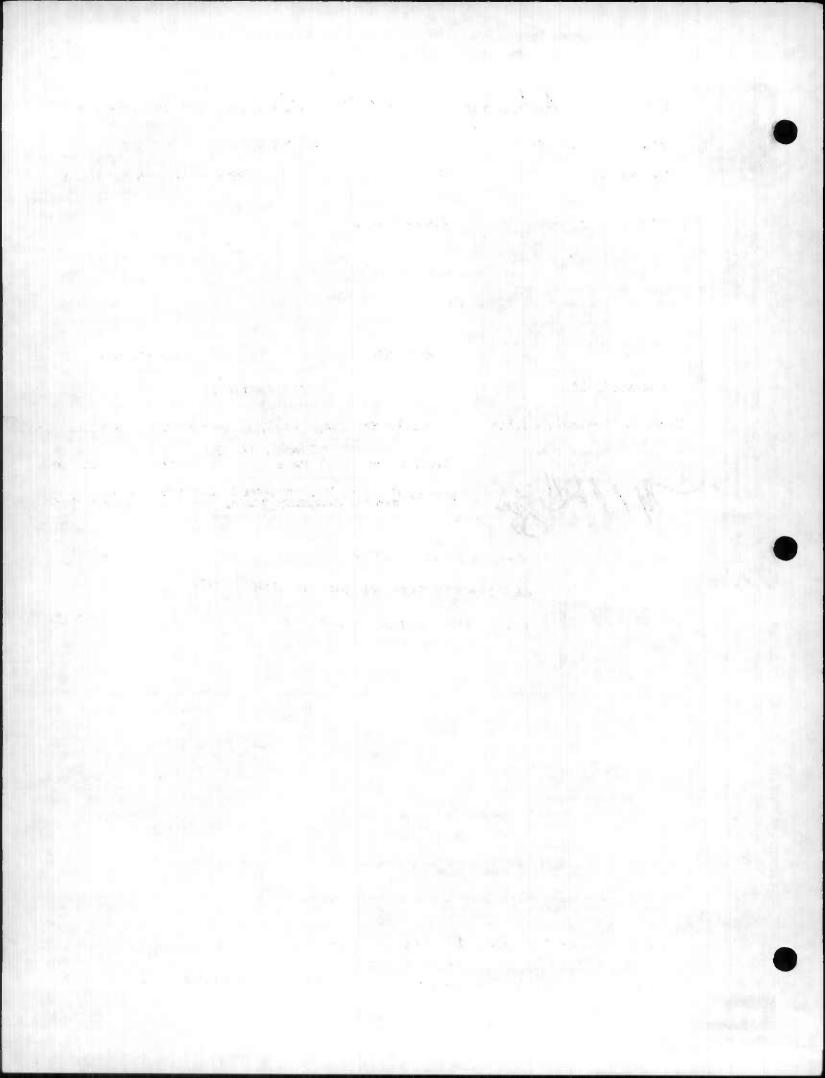
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Dey, Year) Reddy D. Vikramadityk MD 1997 143464 441 09 NOVEMBER 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

SUITE 303, ROCKVILLE, ND -20852

State Registrar

VIKRAYADITYA. D. REDDY, 11125 ROCKVILLE PIKE,

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. Amend #9, 11/12/97, BW, Montg. Co per F.H. State of Maryland / Department of Health and Mental Hygiene 9 7 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Franklyn Yasmer Nov. 3, 1997 10:38pm /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Aga (In yrs. last birthday) If Undar 1 Yaar | if Undar 24 Hrs. 8. Date of Birth Manth, Day Year 1905 5. Social Security Number 9. Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours Min. 125M 2□ F 92 577-32-1251 Yrs Director ON Usuai Rasidence of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Examiner must be notified at Director Montgomery Bethesda 1 ☐ Yas 2 No 288-1 the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 5 234 Funeral 5225 Pooks Hill Rd. 324 South death 20814 United States Hems 12. Was Decadent Ever In U.S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amarican Indian, Black, White, atc. be filed within 72 hours efter d ntel Hygiene. d other then "neturel", or flen event, the Medical Examples 1 ☐ Yas 2 █️No If Yes, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 □ Navar Married 2 □ Married Specify: White 1 Yas 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lita. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Attorney Law-Self Employed 17. Fathar's Nama (First, Middla, Last) s 1 and 2 should be fill f Heeith and Mentel Hi tem 27 is marked oth other traumatic even 18. Mother's Nema (First, Middla, Maidan Sumama) Be Benjamin Yasmer Minya Shankman 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) Elliot Yasmer-Son 5225 Pooks Hill Rd. 324 S. Bethesda, MD 20814 Item 2: 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State Pages 1 1 XBurial 2 Cramation 3 Ramoval from State = 0 permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery Adelphi, MD 11797 22. Nama and Addrass of Facility
Edward Sagel Funeral Direction -Daniel Simons 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Entar the disease shock, or heart short or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximete Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical Urosepis Examiner Due to (or as a consequence of): Examiner Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last burial-tren Dua to (or as a consequence of): physician the burial Physician/Medical Dua to (or as a consequence of). 60 for use detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 0 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ De ed 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? pege 2 hes 1 ☐ Yas 2 ☐ No certificate 1 ☐ Yas 2 ☐ No director. Be 25. Was casa refarred to medical axaminar? 26. Place of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 1 ☐ Yas 2 No this luneral 27. Manner of Deeth 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred After Division or Attending 5 Panding 1 Natural after death. 1 Yas 2 No Invastigation 2 Accident 6 Could not be detarmined 3 Sulcida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) Location (Streat and Number or Rural Routa Number, City or Town, Stata) in by 4 - Homicida within 24 hours a To the Funeral C Hospital 29a. Certifier Medicai 1 🔀 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, data and place, end due to the cause(s) medical manner stated.

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30. Nama and addrass of person who completed deusa of death (Itam 23a) (Type, Print)

Morton Shapiro, MD 5225 Pooks Hill Rd. Bethesda, MD 20814

29c. Licansa number

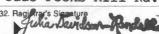
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29d. Data signed (Month, Day, Year)

Nov. 4, 1997

State Registrar

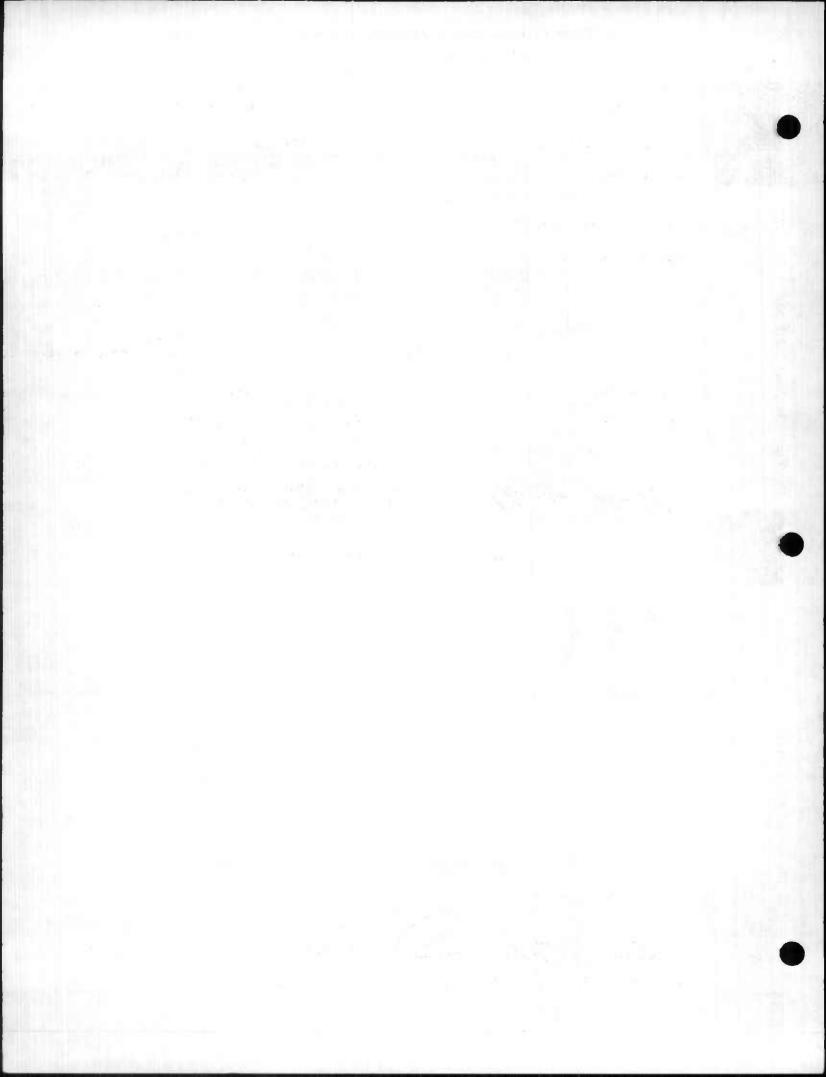
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State of Maryland / Department of Health and Mental Hygiene 7 3575

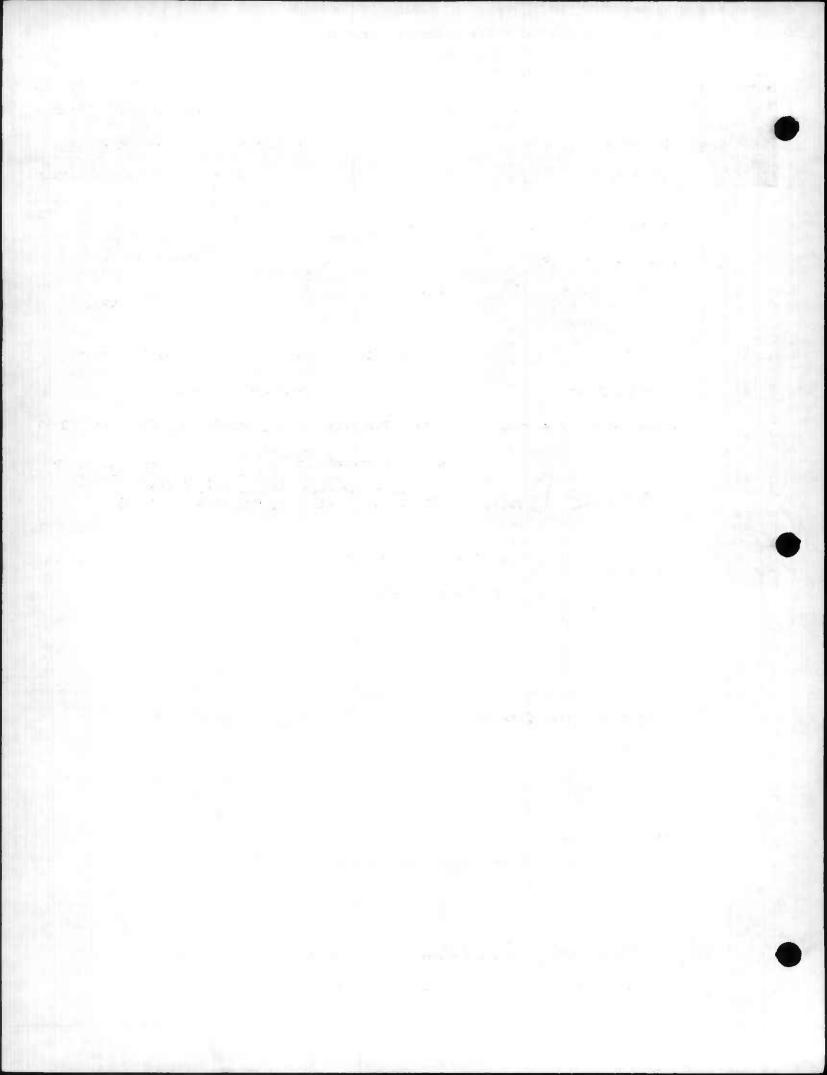
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	4	Matthe C	ihl		S	ilver S	pring, MD	20901				
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	-	30. Nama and address of person wh	o complated causa of d	aath (Iten	1 23a) (Type	, Print)					market marketing	-
		4701 Randolph R	oad, Rockvi	ille,	MD	20852	Sur	esh C. G	ıpta			



State of Maryland / Department of Health and Mental Hygiene 97 35755

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aminer	4	la. Facility Name (If not institution, gir	ve street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
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al or	5		Sex 7. Age NGM 2□ F	(In yrs. last birth	Months Da		(Month, Da	y, Year)	9. Birthplace (: Country)	
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o Be	5	Casimir Zelonis							,	
To		19a. Informant's Name/Relationship		19b. N	Aailing Address (Str	Josephi eet and Number or Ru			State. Zip Code)
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	2	20a. Method of Disposition	.S/WITE						City or Town, Si	
	ŀ	1 XBuriai 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Cotto	Crematory or other	Nov. 10,	1997	242		
	1	11. Signature of Funeral Service Line		Gale o	I Heaven	dress of Facility Rob		Silver	Spring,	MD 1 Ho
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edicai	2	19b. Signature and title of certifier	mu ated cause of de	01 Medic	D3 /pe, Print) al Park D	5996		November	6, 199	7

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Amend #5, 11/14/97, BMW, Montg.Co Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 9, 1997 2:20 am Nov. Rose Zimmerman /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Montgomery Hospital Bethesda Suburban if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Sociel Security Number **Funeral** 1□ M 2 F Months Deys Yrs. 578-05-8482 Usuel Residence of Deced Director Oct. 27, 1914 New York the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Silver Spring Director Md Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? US 15115 Interlachen Dr. #106 20906 2 should be filed within 72 hours after death is and Mental Hygiene.
Is marked other than "natural", or items 23. Funerai 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Orlgln? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 🌠 No Specify: Specify p 3 Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Retail 9 Sales 18. Mother's Neme (First, Middle, Melden Surneme) 17. Fether's Neme (First, Middle, Last) Esther Seigel Simon Herson 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) permit. Peges 1 and 2 st Depertment of Health and Important: If item 27 Is n any Injury or other traun 9520 Duffer Way Gaithersburg, Md. 20879 Paul K. Miller 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, cremetory or other piece) 20c. Location - City or Town, Stete M Burial 2 ☐ Cremetion 3 ☐ Removel from State King David Memorial Gardens 11/10/9Falls Church, Va. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Edward Sagel Funeral Direction 21. Signeture of Funeral Service Unions 1091 Rockville Pike Rockville, Md. 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) HEPATO - RENAL SYNDROME 2 WEEKS Examiner Due to (or es e consequence of) Examiner LIVER CIRRHOSIS OF physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Last Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, HEPATITIS VIRAL Physician/Medical Due to (or es a consequenca of) attending ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 3 ☐ Probably 4 ☑ Unknown 1 Yes 2 No MELLITUS DIABETES by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed MYPERTENSION certificate hes 2) No GI BLEED 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certifica 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1) Inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28e. Dete of Injury (Month, Dev Yeer) 28c. Injury et Work? Certification: 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 HomicIde Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end manner steted. 29a. Certifier Medical To the F within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier MD. D 35941 NOVEMBER 30. Neme end eddress of person who completed cause of death (item 23e) (Type, Print) 50 W EDMONSTON DR ROCKVILLE MD 20852 # 401 MATHUR 32. Registrer's Signeture State Julia Davidson Registrar

Continue to the later to the la

Physicia /Medic Examin

Funerai Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examiner must be nutified at once.

Physician /Medicai Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

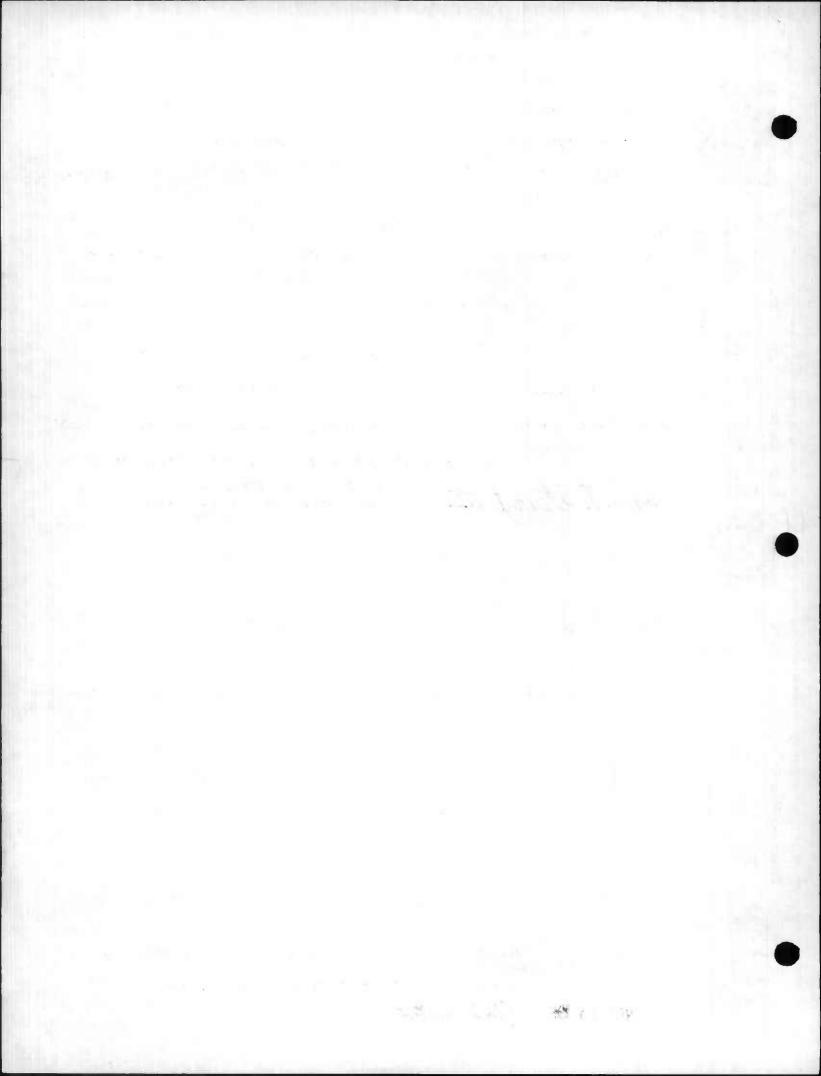
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MD GENERAL HOSPITA	AL E.R.			BALTIM	ORE	CITY			
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Maryland		Baltimore	e						1 X Yas 2
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State Registrar

Dennis 7- () 31. Data filed (Month, Day, Year) NOV 14 1997

32 Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 7 7 5 9

						Certifica	te of	Death		Reg. No.	0	0/0	0
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	Exami	ner	4a. Facility Neme (If not institution, gi	ve street and number)					or Location of Dea	1	nty of Death		
			5118 Martin Dr.			H Hade		Oxon Hi				orge's	
	Funeral Director		5. Social Security Number 6. 218–20–6036 Usuel Residence of Decedent	Sex 7. Age (I 1	n yrs. last bir	Yrs. Months	Days	If Under 24 H Hours M	in. June	orth (1925) 26,1925	9. Birth Con Wash	nplace (State untry) ington	
	nylanc how		10a. State 10b. County	16	Oc. City, Town	or Location						10d. Inside (City Limits
	the Marylar 28a-f show notified at	cto	Maryland Prince (George's	Oxon H	ill						1 Yes	s 2 No
	th with th	ai Director	10e. Street and Number 5118 Martin Dr.				p Code 2074	5		10g. Citizen o		untry?	
	dea	Funerai	11. Marital Status	12. Was Decedent Eve	r In U,S.	13. Was Dece	edent of h	dispenic Origin?	(Specify Yes or Nerto Rican, etc.)		ece - Amer leck, White	rican Indien,	
21215-0020	d 2 should be filed within 72 hours efter death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, its Mexical Exprirer must be notified as	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1. Dives 2 No if Yes, Give Year or Dates: 19	43-46	1 ☐ Yes		Specify:	one mount, etc.)		eity: Wh		
5-0	72 h	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a.	Decedent's Use (Give kind of w	ork done	during most of	working	16b. Kind of	Business/I	ndustry	
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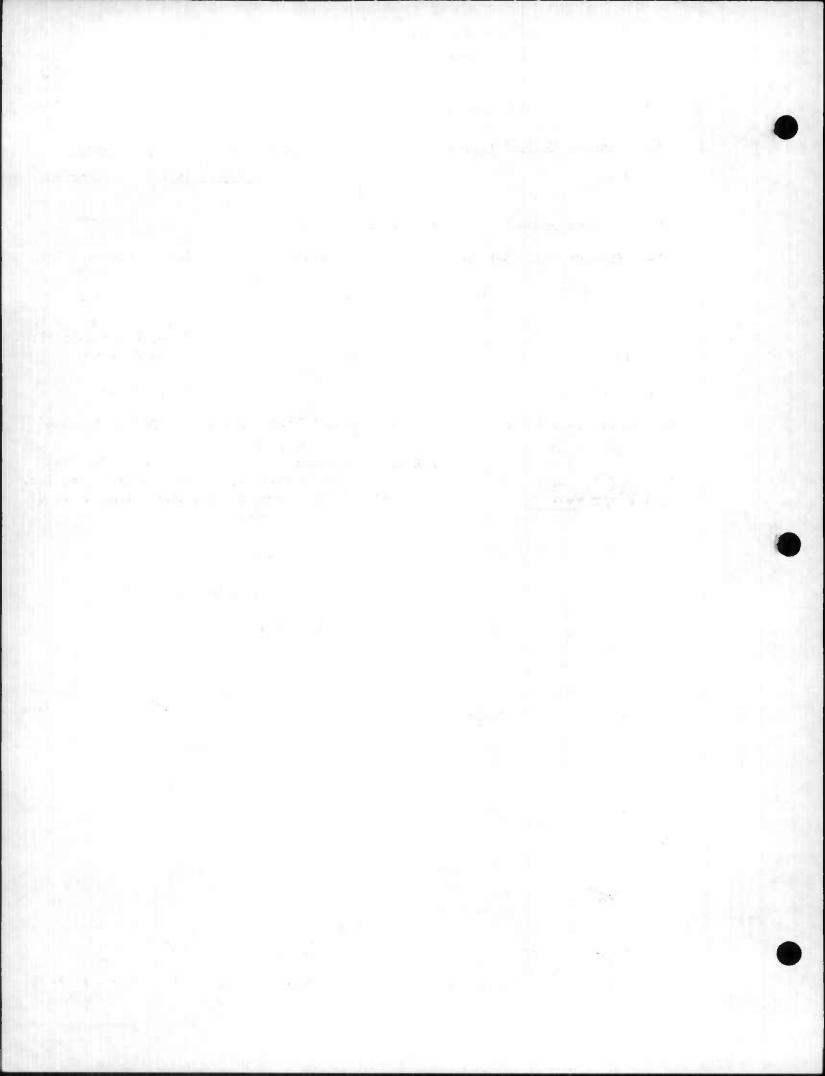
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** J. BUAIR Month 0048 HUNRI /Medical 4a. Fecility Neme (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** if Under 1 Year If Under 24 Ths. 18. Date of Birth (Month, Dey, Year) Anne Arundel Medical Center Anne Arunde 1
9. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. lest birthday) **Funeral** 1**∑** M 2□ F Yrs. Director 570-07-7822 88 Califorina March 2 1909 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show be notified at XIX Yes 2 No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Herms 23a 21403 1142 Pinemont Place Apt 2A United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 "natural', or 1 Yes 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life, DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Federal Communications Elementery/Secondary (0-12) College (1-4or 5+) Commission Engineer then of Health end Mental Hy at: If Nem 27 is marked with y or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Pages 1 and 2 should be Frank Baliros Marie Lapouble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1142 Pinemont Place Apt. 2A Annapolis, MD 21403 Mildred J. Blair (Wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Nov 5, 1997 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
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Important: If itse
any Injury or ott 1 ☐ Burial 2 🏋 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland 21. Strature of Fungral Service Licensee 22. Name and Address of Facilityohn M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Onset and Deeth Physician /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner STAPIT AVEOUS) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Box 68760 Physician/Medical P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed be det Records, g 24b. Were eutopsy findings evellable prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 ☐ Yes 2 ☐ No certificete Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica stely filled in by the funeral director; Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Yes 2 No Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Neturei 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dev. Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Riplicy Arr, Annapous, MO TOPHEN C. Hamilton, MO
priled (Month, Day, Yeer)

32. Begistrars Signature 205 31. Date filed (Month, Day, Yeer) State The Davidson-Randall NOV 05 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Dey Year NOVEMBER 2, 1997 Month **Physician** 12' AM WALTER BRITT /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES ELMLEAF 312 AVENUE SEAT PLEASANT Hours Min. 8. Dete of Birth (Month Day), 1942 If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Deys M 2DF North Carolina 55 241-64-6579 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adreal Examiner must be notified at Yes 2□No Director Maryland Prince George Lanham 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 20706 United States 9877 Good Luck Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whife, etc. 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ZNO Specity: by Specify: Black 3 Widowed 4CXDV orced permit. Peges 1 and 2 should be filed within 72 hc
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturn
any injury or other traumatic event, the Medical
once. Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Board Of Education Elementary/Secondery (0-12) 12th College (1-4or 5+) Asst. Mechanic Prince George 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Mae Vaughan Richard Britt 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Richardson Cousin 7427 Crane Place Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Melhod of Disposition 20c. Location - City or Town, State 1 XBunal 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Harmony Memorial Park 11/8/97 Landover, Maryland 22. Name end Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave, NW Wash, DC 20011 23a. Pentl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting In death) /Medical HYPERTENSIVE ARTERIOSCIEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of): Examiner ician and buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lesf Due to (or as a consequence of): physician the burie Box 68760 Physician/Medical Due to (or as e consequence of) 88 9SM signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS Records, þ requires 24b. Were autopsy findings aveileble prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital o the Hospital or Attending Physician: ithin 24 hours after death.

• the Funeral Director: After this certifica director, Be 25. Was case referred to medical 28. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Division of funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending hours effer death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - Al home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner staffed. 29d. Dale signed (Month, Dey, Year) NOVEMBER 02, 1997 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 MARIO F. 3001 Registrar's Signature 31. Defe filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Day Manth 6-97 CHARLES ALVIN BUTLER 11:45am 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death P.G. COUNTY HOSPITAL P.G. COUNTY CHEVERLY if Undar 24 Hrs. Hours Min. 5. Social Security Number If Undar 1 Year Sex X M 2□ F 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, 5-19-21 9. Birthplaca (State or Foraign Months Days MARYLAND Yrs. 212-18-4568 76 Usual Rasidance of Decedent 10c. City, Town or Location 10b. County 10d. fnside City Limits P.G. COUNTY CAPITOL HEIGHTS Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? 505 SUFFOLK AVE. 20743 USA 12. Was Dacedent Ever in U.S. Armed Forcas? Was Dacedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian. Biack, Whita, atc. Yas 2 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Specify: Widowed 4 Divorced 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Coilega (1-4or 5+) POSTAL WORKER FED GOVT 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meldan Sumama) CORNELIA E. BUTLER PEARL OLDS 19e. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) CHARLES A. BUTLER /SON 3425 MEDINA LANE BOWIE MD 20017 20b. Piaca of Disposition (Name of cemetery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 11-13-97 CHELTENHAM MD MD VETERAN - CHELTENHAM 22. Nama and Address of Fecility
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Box 68760, Records, P.O. Division of Vital

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29b. Signature and title,

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28a-f show

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tra Madical Examiner mant be notified at

Hygiene.

Pages 1 and 2 should be file ment of Health and Mental Hy ant: If item 27 is marked oth ury or other traumatic event

permit. Page Department of Important: If eny Injury or once.

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Maryland

Baltimore,

The law requires that the death certificate be executed Sec certificate al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, pa illed in by 24 hours Hospital To the Hosp within 24 hor To the Fune completely fi

State Registrar

30. Nama and eddrass of person who completed causa of death (Item 23e) (Type, Print)

32. Registrar's Signatura

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idical Examiner: On the basis of axaminetion end/or investigetion, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and menner stated.

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29d. Data signed (Month, Day, Year)

29c. Licanse number

State of Maryland / Department of Health and Mental Hygiene 97 3576

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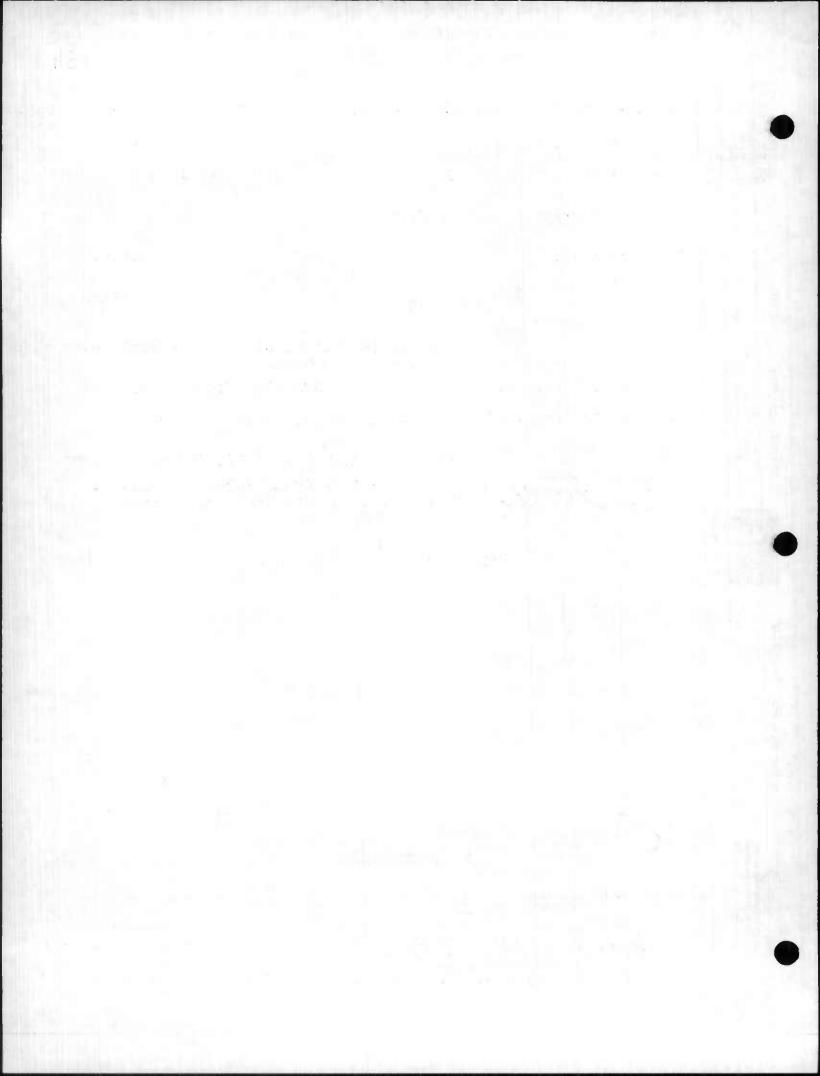
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State of Maryland / Department of Health and Mental Hygiene

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	ng P	on:	27. Menner of Deeth 1 □ Naturet 5 □ Pending	28e. Dete of tnjury (Month, Dey Year	r) 28b. Time Injur	of 2	28c. Injur Wor	y et k?	28d. Describe hor	w injury occur	red	
Sio	Attending or death. octor: After by the fune	cati	2 ☐ Accident investigation			М	10	Yes 2 □ No				
Division	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - A building, etc. (Sp.	At home, farm, ecify)	street, fector	y, office		28f. Location (Str. City or Town,	eet end Numb Stete)	er or Rural Roul	te Number,
	e Hosp 124 hou e Fune Hetely fil	edical	29a. Certifier (Check only one) Certifying Phy	teicien: To the best of my ther: On the basis of examend menner steted.	knowledge, de Inetion end/or	ath occurred Investigation	et the tir , in my o	ne, dete end plece, pinion, deeth occur	end due to the ce red et the time, da	use(s) end me te and ptece, i	enner es steted. and due to the c	ause(s)
	roth roth comp	Me	29b. Signature end title of certifier			290	c. Licens	e number	29	d. Dete aigne	(Month, Day, 1	Year)
	> - 0		> ferish	17.	ROTH	~ D	283	52	No	vembe.	r 13,	1997
			30. Neme end eddress of person who co Krishan Mathu	ompleted cause of death (Item 23a) (Typ	e, Print) Box 2	729	, La Pl	ata, MD	206	46	
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registrer's Si								
	Sta	re	MOVA 5 100		. 0							



State of Maryland / Department of Health and Mental Hygiene 7

						Ce	rtificat	e of	Death			Reg. No.	J	3103
П	D 1 -1 -1		1. Decedent's Neme (First, Middle, L	ast)	023 ATR	a Dill	1		S. BIT	100	2. Date of D		Vaar	3. Time of Death
ı	Physici /Medi		ISABELLA	BRUE	MARE	614					NOVEM	BER 12,199	Year 7	12:52 AM
Ì.	Exami		4a. Facility Neme (If not institution, g.				- 4		4b. City, To	own, or L	ocation of Dea			
П			PHYSICIANS MEMORIAI	L HOSPITAL	_				LAPLA	ATA		CHAR	LES	
r	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs.						8. Date of B	irth	9. Birthp	place (State or Foreign
	Director	8	219-54-6991	1□M 2XF	85	Yrs.	Months	Days	Hours	Min.	Nov 2	8, 1911	Bel	gium
u	D.		Usual Residence of Decedent											9
	anylar show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						1	Od. Inside City Limits
	Pad a	cto	Maryland Char	les		Bel A	1ton							1 ☐ Yes 2 No
	or 2	Director	10e. Street and Number				10f. Zlp					10g. Citizen of	Whet Cour	ntry?
	23a	Ta.	9295 Crain H	ighway			21	061	1			U.S	.A.	
	within 72 hours after death with the Maryland ena. ena. than "natural", or items 23a or 28a-f show the Model Examines the motives.	Funeral	11. Maritel Stetus	Armed Fo		J,S. 13.	Was Deced	lent of I	Hispanic Orlean, Mexicar	lgin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	o- 14. Ra	ce - Americ	
20	or i	by F	1 Never Married 2 Married	If Yes, Gi	ve		1□ Yes					Specia		ite
8	hour		3X Widowed 4 □ Divorced	Year or E	Dates:								AATT	
21215-0020	in 72 ho	Completed	15. Decedent's E (Specify only highest g			(Give	dent's Usue kind of wor	k done	durina mos	st of work	ing	16b. Kind of B	usiness/In	dustry
12	within	E	Elementery/Secondery (0-12)	College (1-4or 5+)		el O					Mot	01	
	Hygi Hygi Her Her		17. Father's Neme (First, Middle, Las	et)		MOL	er o	per		er's Nam	e (First Middle	e, Meiden Sumai		
an	should be filed within 72 hours not Mental Hygiena. marked other than 'natural', imatic event, the Medical Exa	Be C	Edward Maes	•										
2	should ind Men marke	2	19a. Informant's Name/Relationship	(Tuno Brint)		10h Maili	no Addrono	/Caron				lykx Ma		Ondal
Maryland	2 8 9 8	10	State of the state		la de o na		_							Code)
	permit. Pages 1 and 2 Department of Haaith Important: If item 27 I any injury or other tri		Kathy I. Ping	s/daug		Place of Dispo			о ве	I A.	Date	MD 206		www. State
Baltimore,	Pages lent of mt: If its iry or o	1	1 Burial 2 □ Cremetion 3		State	cemetery, crea	matory or o	ther pla				110 15 100		
ţ	f. Part	1	4 Donation 5 Other (Spec		-						s.11/1	5 Wald	ori,	MD
Bal	permit. Pages Department of Important: If it any injury or once.		21. Signeture of Funeral Service Lice	ensee MO	0817	2	2. Name an	e ha	ess of Facili	cho:	ls Fur	eral H	ome	
	402 6 4		Hayton C.	Elist	70		P.	0.	Box .	567	La Pl	ata. M		646
П			23a. Part1. Enter the disease, or cor shock, or heert failure. List only	mplications thet o	caused the dea	th. Do not en	ter the mod	e of dyl	ng, such as	cardiac	or respiretory	arrest,	1	Approximate Interval Between
١.	Physician	н											1	Onset and Deeth
	/Medical Examiner		Immediate Cause (Final diseese or condition	. 70	chem	(2000			110				
п	LAdimilei	ы	resulting in death)	u	Due to (or as e conse	quence of):		ande	hor	-		1	
h	D ===	ine												
	eath certificata be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions,	U.	Due to (or es a c <i>ons</i> ec	quence of):				200			
50,	cian a		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	C									W. F.	
68760,	ohysie the t	edical	that initiated events resulting in death) Lest		Due to (d	or as e consec	quence of):							
9 x	ling p	3		l d										
Bo	death c	an Z		d										
0	the a	Physician	Part II. Other significant conditions	contributing to d	eath but not res	sulting In the u	nderlying c	ause gi	ven in Part i	1.	23b. Dio	tobacco use co	ntribute to	the cause of death?
9	that the de led by the a datached										1	Yes 28No	3 Pro	bably 4 Unknow
S,	SE E	p					100							
Records,	v requires been sign should be	ted									24a. Wa per	s an eutopsy formed?	av	ere autopsy findings ailable prior to
ec	2 s S	pje		Table									of	mpletion of cause deeth?
Œ	The page	Completed									10	Yes 2 No	10	Yes 2 No
Vital		Be (25. Was case referred to medical examiner?						26. Place	e of Deat	h (Check only	one)	1	
of <	2 00	Tol	1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatler	nt 3 DC	A Ott	her: 4 🗆 Nu	ursing Ho	me 5 Res	sidence 6 Ott	ner (Specif	(y)
			27. Menner of Death	28a. Date	of Injury th, Day Year)	28b. Time o	f 2	8c. Inju Wo	ry at		28d. Describe	how injury occu	rred	
0		atic	1 ANatural 5 ☐ Pending 2 ☐ Accident Investigation		,,,	ju.y	М		Yes 2	No				
Division	or Attendia aftar death. Director: A 3 in by tha fu	tific	3 Sulcide 6 Could not determined	be 28e. Place	of Injury - At h	ome, farm, sti	reet, factory	, office			28f. Location	(Street and Num own, State)	ber or Rura	Route Number,
	s aft.	Certification:	7 2 1101111010	Dulla	ing, etc. (opecia	<i>y</i> /					Only of Te	own, Olato)		
	To the Hospital or / within 24 hours aftar To the Funeral Directornpletaly filled in b		29a. Certifier 1 Certifying P	hysician: To the	best of my kno	wiedge, deat	n occurred	at the ti	me, date an	nd place,	end due to the	cause(s) and m	anner as s	teted.
	he Hin 24 he Fi	edicai	(Check only 2 Medical Exa	end man	ner stated.	otion and/or in	vestigation,	in my c	opinion, des	ath occur	red at the time	, date end place,	end due to	the cause(s)
	To To t	Σ	29b. Signature and title of certifier			As 3	290	. Licen:	se number			29d. Date signe	ed (Month,	Dey, Year)
			1	~ <	= '			D-25	5922			1/11	2/2	7
			30. Neme and address of person who	completed caul	se of death (Ite	n 23a) (Type,	Print)			119		THE REAL PROPERTY.		
			KHADAR BAIG M.D	6620	CRANE H	CHWAY .	P.O. P)X 10	m n	APT AT	A MD. 20	16/16		
	Sta	ite	31. Date filed (Month, Day, Year)	32 F	legistrar's Slag	ature		ner - L	L	w TV1	A FID. A	040		
	Registr	ar	NOV 1 7 19	397	hi drive	Ger Kard	all							
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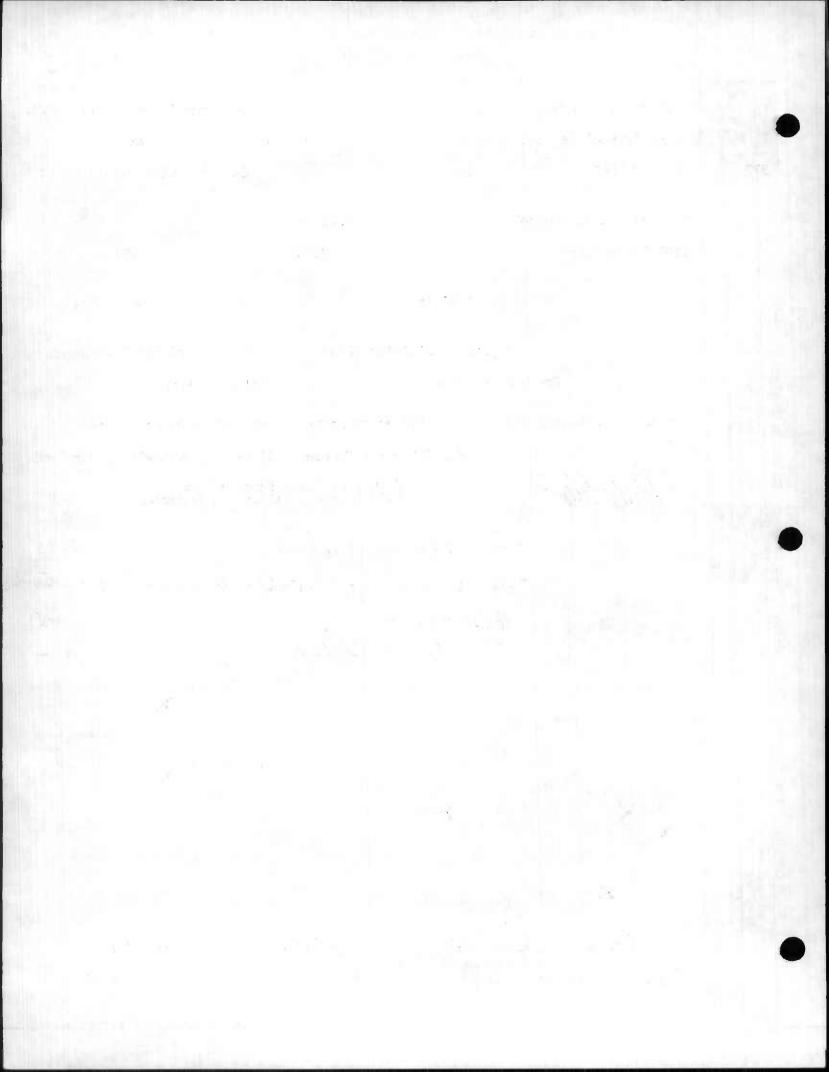
DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Certificate of			g. No. 97	35766
Physic	ian	1. Decedent's Name (First, Middle, La	ast)				2. Date of Death Month		3. Time of Deeth
/Med		Robert J. Colema					Novembe		
Exami	ner	4a. Fecility Name (If not institution, git				4b. City, Town, or L		4c. County of	Death
		Anne Arundel Med			is I Indox 1 Voc	Annapolis		Anne Ar	
Funeral Director	_	5. Social Security Number 6. S 577–32–0895 Usual Residence of Decedent	Sex 7. A	ge (in yrs. lest birt	hday) If Under 1 Yea Months Deys		8. Date of Birth (Month, Dey, Jan. 26	,1927 V	B. Birthpiece (State or Foreign Country) Vashington, DC
land w		10a. Stete 10b. County		10c. City, Town	or Locetion				10d. Inside City Limits
Mary F sh	Ş	Maryland Anne Ar	Indel		Edgew	ator			1X Yes 2 No
1 28s	Director	10e. Street end Number	under		10f. Zip Code	atei	10	g. Citizen of Wh	et Country?
h with	ai D	1109 Shore Drive				21037		I	JSA
dea	Funerai	11. Marital Status	12. Was Deceden Agned Forces	t Ever In U,S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp	pecify Yes or No-		American Indian, White, etc.
ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, ms Medical Evantine must be notified at	by	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1/ Yes Cive	1945–46	1 ☐ Yes 2X No		Trican, etc.)	Specify:	White
5-C	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usuel Occu	pation	cina 1	6b. Kind of Busin	ness/industry
d 2121 filed within Hygiene. ther then	Completed	Elementary/Secondary (0-12)	College (1-4or		(Give kind of work done life. DO NOT use retin				
d 212 filed with Hygiene. fther than		17 Fethodo Namo /Fint Middle Leas	-	ars Div	vision Chie				Government
Maryland 2 should be filk th and Mental Hy 7 is marked oth traumetic event	Be	17. Father's Name (First, Middle, Last	rank J. C	oleman			e <i>(First, Middle, M</i> eborah Re	,	
larylan 2 should be and Mental 6 marked o	10	19a. Informant's Neme/Relationship			Mailing Address (Stree				20 Octob
and 2 sauth ar n 27 le		Pauline V. Colema							
re, N s 1 and r Health tern 27 other tr		20a. Method of Disposition		20b. Place of	D9 Shore Dr Disposition (Name of y, crematory or other pla	ive rage	Water, Ma	ary Land Oc. Location - Ci	ty or Town, State
0 00		XX Burial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State		teran's Cem		_5_97 C	rown evil	le, Maryland
Baltim bemit. Pag Department important: h any injury o		21. Signaturo Funeral Sepyde Lice			22. Name end Addr		3 77 01	COMITSVII	ie, narytanu
Depa Impo		> Varatillala			George P.	Kalas Fu	neral Hon	ne	, Md. 21037
_		23a, Part1, Enter the disease, or com	plications that cause	ed the deeth. Do n	29/3 Solo	mons Islan	nd Rd. Ed	lgewater	, Md. 21037 Approximate
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	line.		1 0		01,	Interval Between Onset end Death
/Medical		Immediate Cause (Final	Ros	shira k	on to	lus			2hcs
Examiner		disease or condition resulting in death)	8.	Due to (or es a.c	onsenhence of	co.	, ,		0 0
	ner		. ruet	asta P	C COL	1001- (+	-lioblas	ma Mu	Stofone 5mm
t. BOX 68/60, death certificate be executed e attending physician and ed for use as the burial-transit	Examiner	Sequentially list conditions,	Ь.	Due to (or as a c	onsequence of):		9	<i>D</i> , <i>G</i> , <i>G</i>	
Se exercian a		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Hak	extens	wn				mos
68/60, ficate be ex physician is the buria	Aedicai	that initiated events resulting in death) Last		Due to (or as a c	onsequence of):	7			9
X X X X X X X X X X X X X X X X X X X			d. DIC	nells	nelli	TRUS			years
BOX eath cert attendin for use	ian								
igned by the a	Physician/	Part II. Other significant conditions of	ontributing to death I	but not resulting in	the undertying cause g	iven in Part I.	23b. Dld tob	acco use contr	ibuta to the cause of death?
deta							1 □ Ye	2 2 No 3	Probably 4 Unknown
VITAI HECOTOS, P.O sician: The law requires that the certificate has been signed by th irector, page 2 should be detache	d by						24a. Was an	autoney	24b. Were eutopsy findings
v requir	Completed						pertorm		available prior to completion of cause
The law ate has page 2	du						1.11	1	of deeth?
	ပိ	25. Was case referred to medical					1 ☐ Yes	71	1 ☐ Yes 2 ☐ No
Of VICE Physician: This certific ral director,	OB	examiner?	Hospital:	attenia.	- N - N - N - N - N - N - N - N - N - N	har	th (Check only one		
Phys rthis eral di	-	27. Menper of Death	1 ☐ Inpati	ury 28b. T	patient 3L DOA	4 Li Nursing Ho	ome 5 Resider		
Or Attending after death. Director: After din by the fune	ertification:	1 Natural 5 Pending 2 Accident investigation	(Month, De			ork?]Yes 2□No		, ,	
Atter dea	ifica	3 Suicide 6 Could not b	286. Place of In	jury - At home, far	m, street, factory, office				or Rural Route Number,
d a garage	Cert	4 Homicide	building, e	tc. (Specify)			City or Town,	State)	
UIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai (29a. Certifier (Check only one)	yalcian: To the best niner: On the basis of and manner si	of examination end	death occurred at the t Vor Investigation, in my	ime, date end place, opinion, deeth occur	end due to the car red at the time, da	use(s) and mann te and place, and	ner as stated. d due to the cause(s)
To the vithin round to the	Me	29b. Signature and title of certifier	111	1	29c. Licen	se number	29	d. Date signed (Month, Day, Year)
		Albrus	lel	188m	DU	8101		11/2/0	77
		30. Neme and address of person who	completed cause of	death (Item 23a) (^.	110	1 1
		Jonna Chami	bers MD	1833	A FO Nest I	r. Anna	polis 1	UD 2	1401
Sta Regist		31. Dete filed (Month, Dey, Year) NOV 0 4 19	32. Regist	rar's Signature a Davidsen-	Pandell				

DHMH 16 Rev 6/95



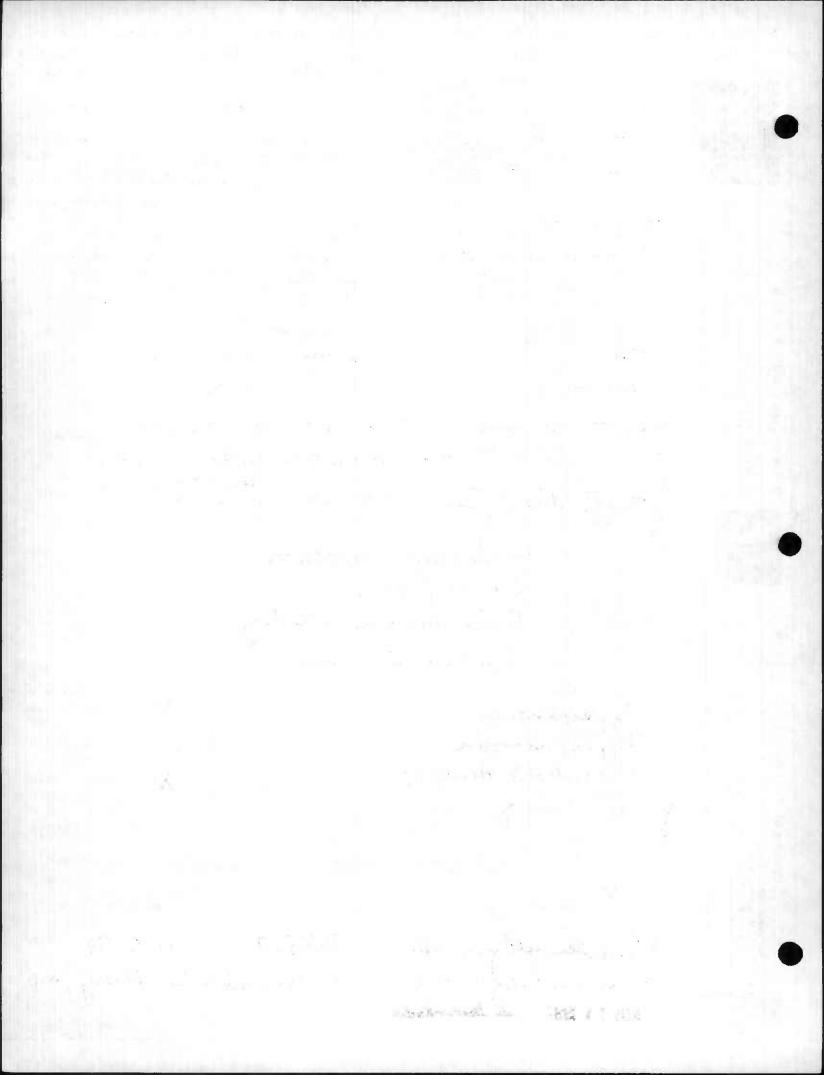
State of Maryland / Department of Health and Mental Hygiene 7 35767

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man natur he Medical	3 Widowed 4 Divorced 15. Decedent's Edi	ALTHOUGH POTCOS /	J.S. 13. Was Dec	edent of His	panic Origin? (Sp., Mexican, Puerto	ecity Yes or No-	14. Rac	e - American ck, White, etc	Indian,
than "natur be Medical	15. Decedent's Edu	1 ☐ Yes 2 TVNo If Yes, Give			Specify:	riioari, oto.)			
d dw		Year or Dates:	10,100	- X	орвону.		Specify	Whi	.te
d dw	(Specify only highest grad		18a. Decedent's Us (Give kind of w	ual Occupat	ion uring most of work	(Ing	6b. Kind of Bu	usiness/Indus	try
Co	Elementery/Secondery (0-12)	College (1-4or 5+)	'life. DO NOT	use retired)	uring most of work				
	8		Cool					Servi	.ce
event, Be C	17. Fether's Neme (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M.	aiden Surnam	ne)	
marked other imatic event, I To Be Co						istina Ko	~ ~ ~ ~		
2 6	19a. Informant's Name/Relationship (T		19b. Mailing Addres						ide)
other tr	Mike Piera (Broth		3030 01d						
2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	Plece of Disposition (No cemetery, crematory or	eme or other place,)	Date 2	0c. Location -	City or Town	, State
han	4 Donation 5 □Other (Specify,		. Demetrius	Ceme	tery 11/	5/97	Annapo	lis, M	fary land
any injury c	21. Signature of Eureral Service Licens	900	22. Name e	and Address	of FecilityJohr	M. Tayl	or Fun	eral H	lome, In
5 2 2	homas) Hum	147 Du	ike of	Glouces	ster St.	Annapo	lis, M	D 21401
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deal	th. Do not enter the mo	ode of dying,	, such es cardiac	or respiratory erre	st,	A	oproximate terval Between
sta s the	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	a. Acute Due to (c. Ayper Due to (c. Ayper	sclerofi or es a consequence of choles or as a consequence of	tere	Heari	Dis	e 454	· u	NK
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y Physician	Part II. Other significant conditions co	ntributing to death but not res	sulting In the underlying	cause giver	ı in Part I.	23b. Did tob	acco use co	ntribute to th	e cause of deat
	Diabetes					1 🗆 Yes	8 2□ No	3 Probab	bly 4 Munkno
page 2 should be o						24a. Was an perform	autopsy ed?	eveila	autopsy findings ble prior to letion of cause
page 2						4.D.V	.V-V.		
Be Co	25. Was case referred to medical					1□ Yes		1 U Y	es 2 No
	examiner?	Hospital:		Othor	,	th (Check only one,			
- F	27. Manner of Death	1 ☐ inpatient 2 ☐	ER/Outpatient 3 C	28c. injury	4 Li Nursing He	ome 5 KDResiden 28d. Describe hov			
in by the funer	1 Netural 5 ☐ Pending	(Month, Day Year)	Injury	Work?	es 2 No	Log. Doddilog nov	r anjury cocur.	.00	
ed in by the funera	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, facto			28f. Location (Stre City or Town,		er or Rural R	oute Number,
completely filled in	29a. Certifier 1 Certifying Phy. (Check only one)	sician: To the best of my kno ner: On the besis of examine	owledge, deeth occurredation end/or Investigatio	d at the time n, in my opli	, date and piece, nion, death occur	and due to the cau	use(s) and ma	anner as state and due to the	rd. e cause(s)
completely filled Medical Ce	29b. Signature and title of certifier	and manner stated.	. 20	9c. License i	number	T 20	d. Date signed	d (Month Day	v Voor)
8	///://	mue	10 00 19				1	1	- 1111
	Alllen	Marin 1	100			/ /			The second secon
	30. Name and address of person who co	ompleted gause of death (Iter		1) 0	1605	erica	11/2	19	7

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State of Maryland / Department of Health and Mental Hygiene

		Decedant's Nama (First, Mid	dla, Last)		Cer	tificate of	Death	2. Data of Deat	g. No.	3	3. Tima of Death
Physic		Madeline V	7. Chew					November	Day	Yaar 997	2:25AM
/Medi Examii		4a. Fecility Nama (If not institut	ion, giva street end numb	oer)			4b. City, Town, or	Location of Deeth	4c. County		2.23AH
	•	Prince Geo	rge's Hospi	tal			Chever1	У	Prin	ce Ge	orge's
Funeral Director		5. Social Sacurity Number 579-28-0113 Usuel Rasidance of Decedant	6. Sex · 7.	Aga (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Undar 24 Hrs Hours Min	. (Month, Day,	Year)	9. Birthple	aca (Stata or Foreign ry) ngton, D.
yland		10a. State 10b. Coun	ly	10c. Cit	ty, Town or Loc	ation				10	Od. Inside City Limits
the Marylan 7 28a-1 show	to	District of C	Columbia		W.	ashingto	n				1 X Yas 2 □ No
or 28	ire	10e. Street end Number				10f. Zip Code		10	Og. Citizan of \	What Count	ry?
th wi	ai	4339 Gorma	n Terrace,	S.E.		2	0019		Un	ited	States
I.Z.I.D-UUZU within 72 hours effer death with the Maryland ene. than "natural", or items 23s or 28s-f show its Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 🕅 Naver Married 2 Ma 3 Widowed 4 Divorce	If Yas Give	ĭX No		/as Dacedant of H Yas, specify Cub		Specify Yes or No- to Rican, atc.)		e - Americe ck, Whita, a	
	Completed	15. Decede (Spacify only high Elamentary/Secondary (0-12) 12th	est grada completed) Coilaga (1-4)	or 5+)	(Giva k lifa. D	ant's Usual Occup ind of work dona ONOT usa ratire	duning most of wo d)	nrking	Designation		
	Be C	17. Fathar's Nama (First, Middle	n, Last)		Nece.	IVING CI		ma (First, Middla, N	Privat Maidan Sumam		odles
Maryland & d should be filed the and Mental Hygin T is marked other traumatic event, I	To B	Richard Ch	ew					Edna McDo		37.	
d 2 should d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailing	Addrass (Street		ural Routa Number,		Stata. Zio	Coda)
CENL		Sharon Willi	ame/Daughte	r				emple Hil			
5 ± 5 ± 6		20e. Method of Disposition		20b. F	Place of Dispos	ition (Nama of atory or othar pla	6 00.		20c. Location -		
Page ent of nt: K i	2	1 XBurial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other		T LCX		demorial		11/18/97	Lando	ver. N	MD.
Definition of permits and permits and permits of them important: if item any injury or other once.		21. Signatura of Funaral Sarvic	Licensee			Nama and Addra	ss of Facility	Stewart F	uneral	Home	
		23a. Parti. Enter the disease.	Surous that call	111	-	1001 Beni	ning Rd.	, N.E. Wa	sh., D	.C. 20	0019 Approximata
tificate be executed to physician and es the burial-transit	edical Examiner	Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated avants rasulting in death) Last	Gas	Dua to (c	or as a consequent of as a consequent	ance of):	ction	hy-			
22 01 0	N/U		d. 36	iru	re D	13 ord	es				
death death death	icia	Part II. Other significant condit	lone contributing to death	h hut not res	ulting in the un	tarluina cauca ais	on In Part I	23h Did to	hacco was co	ntribute to	the cause of death?
v requires that the death cer been signed by the ettendin should be deteched for use	by Physician/	Hype	Hensi or	C	uning in the uni	anying causa giv	en in Part I.	1 🗆 Ye	1/	3 Prob	
2 5 8	Completed	Hype	Kalem aboliz t	ia				24a. Was ar perform	autopsy ned?	com	ra autopsy findings ilable prior to applation of causa aath?
The law ete hes page 2	Com	met	aboliz t	teid	0013			1□ Ya	s 2 No	10	Yas 2□ No
ysicien: The s certificete director, pag	Be	25. Was casa referred to medic examinar?						ath (Check only one	a)		
Physician: Tritis certification	10	1 Yas 2 No			ER/Outpatient		4 Nursing F	foma 5 ☐ Rasida			,
Afte fune	ation:	E LI MOOIGOITE	tigation	njury Da <i>y Year)</i>	28b. Tima of Injury	28c. Injur Wor M 1 □	yat k? Yas 2 □ No	28d. Dascribe ho	w Injury occur	red	
- Page	edical Certification:	4 Homicida	minad 286. Place of building,	atc. (Specif	y)	et, factory, offica		28f. Location (Str City or Town	, Stata)		
To the Hospital Within 24 hours of the Funeral operal filled	dicai	29a. Cartifiar (Check only one)	ng Phyaictan: To tha ba I Examiner: On the basis and mannar	s of axamina	wiadga, daath d tion and/or inva	occurred at tha tir estigation, in my o	na, data and place pinlon, daath occu	e, and due to the ce urred at tha tima, da	use(s) end me ite and place,	enner es ste and dua to	ited. tha cause(s)
to the	Me	29b. Signatura and titla of certifi		em em	.D.	29c. Licens	4596-	7-	d. Data signe	d (Month, D	ay, Year)
(8)		30. Nama and addrass of person	who complated cause of	of death (Itan	23a) (Type, P	Prince	e George	és Hospi	tal C	hera	7 1/4, mD
Sta		31. Data filad (Month, Day, Yaa,	1007 33/ February	istrar's Signa	itura	Prince	e George	jes Hospi	tal C	heva	ily.



State of Maryland / Department of Health and Mental Hygienen

sicia	n	1. Decedent's Name (First, M.								Date of Deat	Dey	Year	3. Time of Death
edica	_	Kitty		Ann Carro	11					WEME	SER 10,	1997	12:304
mine	er	4a. Fecility Name (If not institu Prince Georg								ition of Deeth	4c. County		
ral	-	5. Social Security Number	6. S		e (In yrs. la	ast birthday)	If Under 1 Ye	ear If Under	rerly 24 Hrs. 8	Date of Birth (Month, Day,	P.0		lace (Stete or Foreign
tor.		236-62-3299 Usual Residence of Decedent		□M 2⊠F	56	Yrs.	Months De	ys Hours	Min.	Month, Day, June 26	,1941	Coun	Virginia
		10a. State 10b. Cou			10c. City,	Town or Loc						1	0d. Inside City Limits
	Funeral Director		G.					ttsvill	.e				1 XYes 2 No
1	2	10e. Street and Number 4818 Trento	on I	Rđ.			10f. Zip Cod	20784		1	Og. Citizen of W		try?
	era	11. Maritei Status	71. 1	12. Was Decedent E	Ever in U,S	S. 13. W		of Hispenic Originals Suban, Mexican	gin? (Speci	fy Yes or No-		1-1-1-1	an Indian,
L	by Fur	1 Never Married 2 Nover Marri		Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo		Yes, specify C ☐ Yes 2🔯		, Puerto Ri	can, etc.)	U.S.A s or No- tc.) 14. Raca- Black, Specity: 16b. Kind of Bush D.D.D Middle, Meiden Sumame) H. Blasko Number, City or Town, St Sville, Md.	k, White,	etc. ite
	et ed	15. Dece (Specify only hig				16a. Decede	ent's Usual Oc	cupetion ne during most	of working		16b. Kind of Bu		
	Completed	Elementery/Secondery (0-1:		College (1-4or 5	+>	life. De	o NOT use re	tired)	or working		D.D.	D. C	o. Inc.
	Be	17. Father's Name (First, Midd						18. Mothe	r's Name (First, Middle, A	feiden Sumam	e)	
ř	၉			Plumley						a H.			
		19a. Informant's Name/Relati				19b. Mailing 4818							
	-	20a. Method of Disposition	·OII	(IIusualiu)	20b. Pla		Trent ition (Name or afory or other		нув				
		1 ☐ Burlal 2 ☑Crematic 4 ☐ Donation 5 ☐ Other					Crema		111	/12	River	Alah	Md 207
Allka.	ŀ	21. Signature of Funerai Serv			,								
		Thomas	5	Chambe	m_								
ľ		23a. Pert1. Enter the disease shock, or heart feilure. I	, or comp	plications that caused	the death.	Do not enter	r the mode of	dying, such es	cardiec or I	espiratory arre	est,	T	Approximate interval Between
ı			,	0.4								1	Onset end Death
	1	Immediate Cause (Final disease or condition resulting in death)		· Ve	tasi	atic	01	laria	n (ance	Y		
Ų.	ē				Due to (or	as a consequ	ence of):						13 YRax
li	Examiner	Sequentially list conditions,		b	Due to (or	as a consequ	ence of):						2/-
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	Į	c								1	
dile	edicai	that initieted events resulting In death) Last			Due to (or	as a conseque	enca of):					I	
1.0	100			d								i	
oloi	Cia	Part II. Other eignificant cond	litione co	ontributing to death bu	t not resui	ting in the unc	derlying cause	given in Pert I.		23b. Did to	bacco use con	tributa to	the cause of deat
	Physician/N	Tax III Ollio olgrillogit odlio		minuting to obtain bu	1110010301	ung in the and	sorrying cause	given an each		1 □ Ye	1		pably 4 ☐ Unknow
	od by									24a. Was ar	autopsy	24b. We	ere eutopsy findings
9	Completed									perform	1ed?	COI	eilable prior to impletion of cause death?
1	E									1 □ Ye	s 200 No	1 🗆	Yes 2 No
	Be	25. Was case referred to med exeminer?	-	allows A A					of Death (Check only on	9)		
	0	1 ☐ Yes 2 No		Hospital: 1 Inpetier		R/Outpetient	3D DON		-		nce 8 □Othe)
9	Certification:	27. Manner of Death	ding estigation	28a. Dete of injur (Month, Day	Year)	28b. Time of Injury		njuryet Work? I∐Yes 2∐1		d. Describe ho	w Injury occurr	ed	
16100	lica	3 Sulcide 6 □ Cot	ald not be	28e. Placa of Inju	ıry - At hon	ne, farm, stree						er or Rure	l Route Number,
100	e l	4 Homicide		building, efc	. (Specify)					City or Town	, State)		
	edical	29a. Certifier 1 Certification (Check only one)	lying Phy cal Exam	yeiclan: To the best o liner: On the basis of and manner sta	examinetic	ledge, death on and/or inve	occurred at the estigation, in m	e time, date and ny opinion, deat	d placa, and h occurred	d due to the ca et the time, da	use(s) and ma ite end plece, a	nner as st and due to	ated. the ceuse(s)
1 2	×	29b. Signeture and title of cart	ifier	٨			29c. Lio	ense number		29	d. Date signed	(Month,	Day, Year)
			•			M.	A 1	1 271	127		Non	to	1007
		-204	2w	KINAN		- M.	- (),	7-21	10 -		INDA	21	1771
		30. Name and address of pers	on who o	completed cause of de	eth (Item :	,	rint)	7-27	(0 -		1400	21	1997 1d28770

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State of Maryland / Department of Health and Mental Hygiene 97 35770

						Cel	rtificate o	i Deam		Reg. No.	1		
		Decedent's Neme (First, Middle, Last)							2. Dete of De Month	eth	Vaar	3. Time o	f Deet
Physicia /Medic	_	Avis Chism							11	06	97	8:45	A
Examin	-	4e. Facility Neme (If not instituti	ion, give street a	and number)				4b. City, Town, o	Location of Deet	h 4c. Coun	ty of Deetl	h	
		Holy Cross Hospital Silver								oring montgomery			
Funeral Director									. (Month, De	8. Dete of Birth (Month, Dey, Year) 9. Birthplece (Stete or For Country) 12-09-01 North Caroli			
when relicous one deem will the maryand one. than "natural", or flems 23a or 28a-f show the Modical Examiner must be notified at		Usuel Residence of Decedent											
	Completed by Funeral Director	10c. Stete 10c. County 10c. City, Town or Location 10c. City Town or Locati											
		10e. Street end Number 10f. Zip Code 6006 Mustang Place					20737				Whet Country? USA		
		11. Maritel Status 1 Never Merried 2 Ma 3 Widowed 4 Divorce	Armind 1 If Ye	12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 □ No If Yes, Give Year or Dates:			Wes Decedent of If Yes, specify C 1 ☐ Yes 201	of Hispenic Origin? (uben, Mexican, Pue lo <i>Specify:</i>	Specify Yes or Norto Rican, etc.)	Spec	tace - American Indien, Bleck, White, etc.		
		15. Decede	ent's Education	rede completed) (College (1-4or 5+)			dent's Usuel Occ	cupetion ne during most of w	working 16b. Kind o		of Business/Industry		
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of the	Be (7. Fether's Neme (First, Middle, Last)				18. Mother's			Name (First, Middle, Maiden Sumame)				
th and Mental Hygie 7 is marked other t treumatic event, to	70	Jonah Woody							Ida Mason				
		19e. Informent's Neme/Reletion	nship (Type, Prin				et and Number or F	and Number or Rural Route Number, City or Town, State, Zip C					
alth 127 i		John E. Chis	sm/Son				2 Powel:	ll Lane, Bowie, Maryland			nd 20716		
Department of Health important: If Item 27 i any injury or other tri		20e. Method of Disposition 1						olece) l Park	Dete 20c. Location - City or Town, Stete 1/11/97 Landover, Marylan				
ysiclan Medical aminer		23e. Pert1. Enter the disee e, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, Approximete Intervel Betwee Conset end De Immediete Ceuse (Finel disease or condition resulting in death) e. Acute Congestive Heart Failure 24 hour										te twe	
	-	Due to (or es a consequence of):									1		
	line		A quata N	ute Myocardial Infarction						1			
## (P)	큔		b	Acute I	Myocai	rdia.	1 Infar	ction				5 day	5
and I-transit	xamlı	Sequentially list conditions,	6.	Du	ue to (or es	e conseq	quence of):					5 day	S
clan and burief-transit	al Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury	6.	Du	ue to (or es	e conseq	-					5 day Yea	
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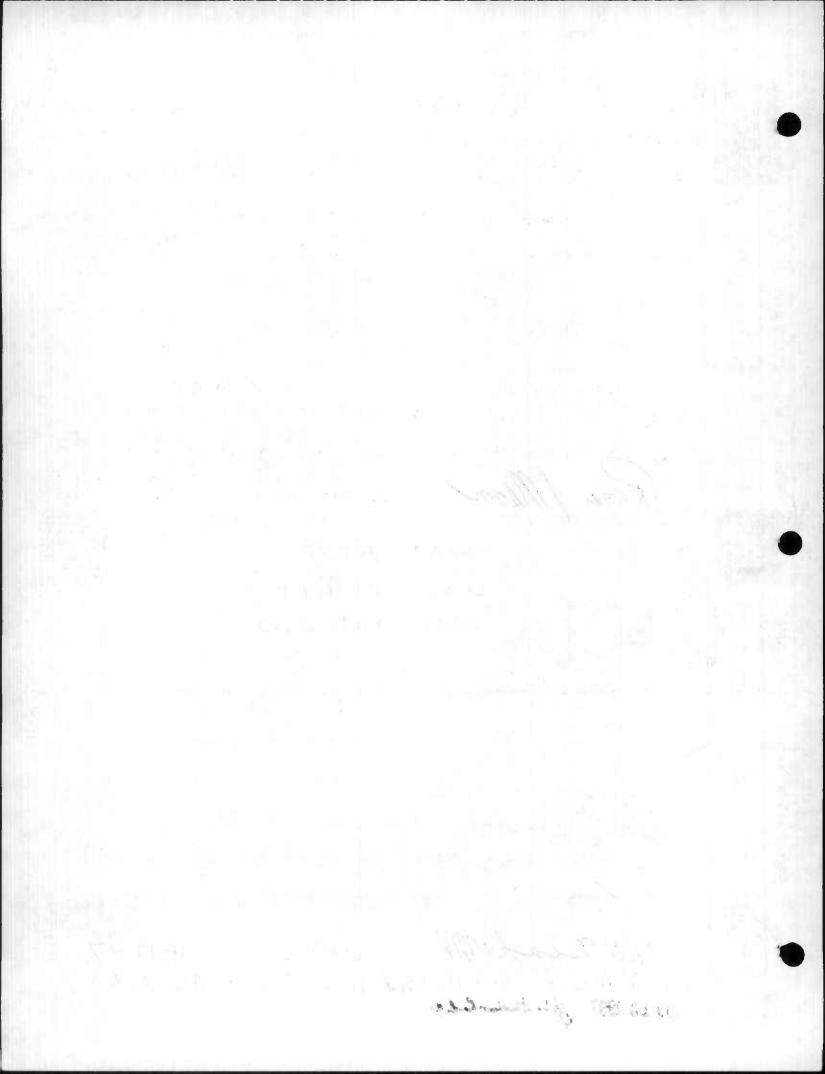
State of Maryland / Department of Health and Mental Hygiene 9 7

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edicai ıminer	r li	4e. Fecility Name (If not institution, give	street and number)					r Location of Deeti	h 4c. County	of Death	
		Magnolia Garder	s Nursin	ng Hom	e		Lanh	an Md	Pri	nce	Georges
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þ		19s. Informant's Name Relationship (7) Shirley Martin,	Friend	19	710	Good Good	Luck Rd	Lanhan	i Ma 20	5/19, Zip	Code)
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Ames		21. Signature of Fugural Service Licens	Mison	/			dress of FecilitySt				
n/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that militated events resulting in death) Last	2 <u>L</u>	Due to (or as a NO NO NO NO NO NO NO NO NO NO NO NO NO	conseque	enca of):	WMA ASTBI	5			
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Me		29b. Signature and title of certifier	adV	m		29c. Lice	nse number		29d. Date signe	d (Month, i	Day, Year)
		10. Name and eddress of person who co	mpleted cause of dee	Mal	Type, Pr	" Pr	ve La	vrel 1	nd 2	070	8



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth **Physician** NOVEMBER 11, 1997 PAHT. CHICOINE 5:30p.m. /Medicai 4a. Facility Nama (If not Institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 Oak Street Indian Head Charles If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number if Under 1 8. Data of Birth (Month, Day, Year) Nov. 27,1910 7. Aga (In yrs. last birthday) Yaar Birthplaca (Stata or Foraign Country) **Funerai** Days 1 XM 2□ F 080-03-5634 86 Yrs. Director Newport, Vermont Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Locetion 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinal must be notified at 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Directo Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 Oak St. 20640 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if Item 27 Is merked other than "natural", or Items 23s any Injury or other traumatic event, the Modical Examinar 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2FTNo If Yas, Give^A A Year or Dates: 11 Marital Status Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) Rece - Amaricen Indian, Bleck, Whita, atc. 1 ☐ Navar Merried 2 ☑ Marriad 1 Yas 2 No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacedant's Education (Specify only highast grada complated) Collega (1-4or 5+) 2yrs. Elamantary/Secondary (0-12) Civil Service Commission Federal Government 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Auguste Chicoine Odile Trahan 19a. Informant's Name/Raiatlonship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) June C. Gates/Daughter 10804 Riverview Rd. Ft. Washington, Md. 20744
aca of Disposition (Nama of Data 20c. Location - City or Town, State 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 1 Burial 2 Cramation 3 Removel from Stata Resurrection Cemetery 4 ☐ Donation S ☐ Othar (Specify) 11/14/97 Clinton, Md. 21. Signature of Junaral Sarvice Licensaa George P. Kalas Funeral Home ales 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 P 11. Entar tha disaase, or complications that ceu shock, or had failura. List only ona causa on aa the daeth. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, Approximata Intarvai Batween Onsat and Deeth **Physician** /Medicai Immediate Causa (Final Inner Cranial Bleeding wo disaasa or condition rasulting in deeth) Examiner Dua to (or as a consequence of) Examiner ettending physician and for use es the bunal-transit Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Diseasa or injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequance of): signed by the el Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably ▼ Unknown by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of causa of daeth? page 2 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No director, 25. Was cesa rafarrad to madical axaminar? Be 26. Placa of Daath (Check only one) Hospital: Othar: 4□ Nursing Homa 5□ Hasidance 6 □ Othar (Specify) 1 Yas 2010 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manger of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant filled in by the 3 Sulcida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a, Certifia Medical (Check only one) 29b. Signature and titla of cartifiar 29c. Licansa numbar 29d. Data signad (Month, Day, Year) November 13,1997 D28352

State

certificate

this

After !

death.

To the Hospital or Attand within 24 hours efter death To the Funeral Director:

with the Maryland

Baltimore, Maryland 21215-0020

certificate be executed

Records, P.O. Box 68760,

Division of Vital Attanding Physician:

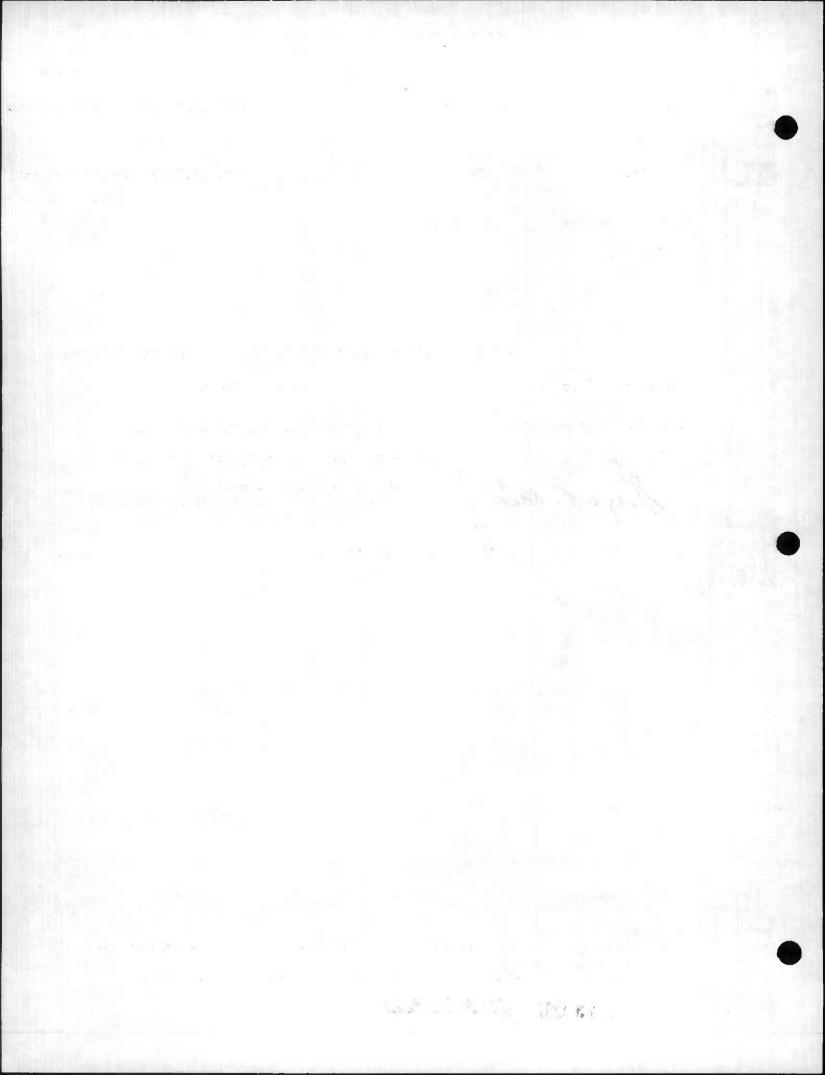
> 31. Data filed (Month, Day, Year) NOV 13 1997 Registrar

Aggistrar's Signature Redell

Krishan Mathur, M.D., P. O. Box 2729, La Plata, MD

20646

30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Typa, Print)



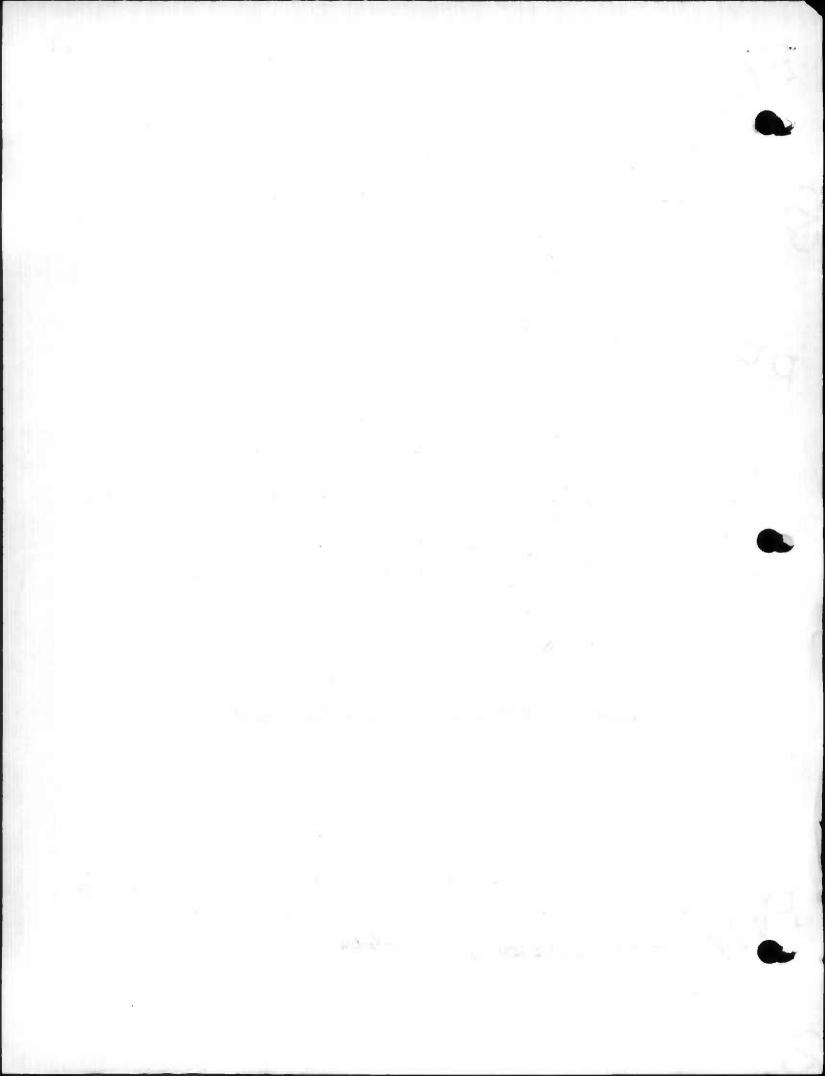
THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within flower after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should	DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
s filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. APORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Hem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF I	MARYLAND / DEPA CERTI
1. DECEDENT'S NAME (First, Middle, L	est)	
ALICE	CRAYTON	I
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest birthday
579-18-2160	t 🗌 M 2 🔭 F	85 YRS.
9a. FACILITY NAME (If not institution, g	live street and number)	

ARTMENT OF HEALTH AND MENTAL HYGIENE

	- REGISTRAR		CE	RTIF	ICATE O	F DEATH		REG	. NO					
10	1. DECEDENT'S NAME (First, Middle, Last)					_		DATE OF DEA				3. TIME OF DEA	ATH	
	ALICE	CRAYTON						ovembe		9. 19	997	8:24	a	м
M	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. less	t birthday)	IF UNDER 1 YEA	R IF UNDER 24 HR	18. 7. 1	DATE OF BIRT	TH	,	a. BIRTH	HPLACE (State or I		
	579-18-2160	t 🗌 M 2 🖫 F	85	YRS.	MONTHS DAY	B HOURS MH		Month, Day, Ye		012	Counti			
	9a. FACILITY NAME (If not institution, give	street and number)	05		9b. CITY TOW	N OR LOCATION O		uly 22	1 و ک		JNTY OF D		_	_
Œ			-47											
5	Washington Adven	LIST HOS	ortar		5111	er Spri	ng		_	Mon	tgom	ery		_
DIRECTOR	10e. STATE 10b. COUNT	Υ		t0c. CIT	Y, TOWN OR LO	CATION						10d, INSIDE CIT	Υ	
	Maryland Prin	ce George	es	Ну	attsvil	le						t XYES 2	NO	
AL	10e. STREET AND NUMBER					tor. ZIP CODE				10g, CIT	IZEN OF	WHAT COUNTRY?		
FUNERAL	5909 Eastern Av	e.				20783					U.S.	Α.		
5	tt. MARITAL STATUS		T EVER IN U.S. AR			ECENDENT OF HIS				or No-	14. RACI	E American Inc	llan,	
BY F	t Never Married 2 Married 3 Widowed 4 Divorced	IF YES, OIVE V	YES 27 N	10		specify Cuban, Me 'ES 2 X NO Sp		arto Hican, et	tc.)		Spec	nille-		
												Black		
COMPLETED	ts. DECEDENT'S EDU (Specify only highest grad	p completed)	(G/	ve kind of Do NOT u	USUAL OCCUP work done during	MTION most of working		16b, KIND C	OF BU	SINESS/IN	DUSTRY			
빌	Elementary/Secondary (0-12)	College (1-4 or 5	+)					- 1		1 0				
M	17. FATHER'S NAME (First, Middle, Last)			Hous	ekeepii				_		vern	ment		_
	17. PATHER'S NAME (FIRST, MIDDIE, LEST)	led Crayto	on			18. MOTHER'S				Sumame)				
BE	19a, INFORMANT'S NAME (Type/Print)							Brydie						_
임	Ruby Frye					et and Number or A						0.2		
	20g, METHOD OF DISPOSITION				OF DISPOSITION		nyat				City or To		_	_
	t 🖟 Buriel 2 🗆 Cremation 3 🗆 Ren 4 🗆 Donation 6 🗆 Other (Specify)	noval from State	cemetery_cred	matory or o	ther place)	La1 Cem.	11/	15/07	C1	4+1 a	and M	A Stata		
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		COIII		AND ADDRESS OF			שנ	ITLIA	.nu m	u.		_
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	11/1/	Just 1	un		389	Rhode I	slan	d Av.	, NV	,Was	hing	ton,D.C	•	
	23. PART I. Enter the diseeses, or ahock, or heart failure.	Complications the	it caused the de use on aach line	ath. Do i	not enter the	mode of dying,	auch as	cardiac or	reap	iratory ar	reat,	Approxim		ın
	IMMEDIATE CAUSE (Final disease or condition			_ /	/		- a		0,			Onset an	nd Daar	th
	resulting in death)	. CONGE	PSTIVE		EHK	7 /	11	LUK						
		b. DIL	(OR AS A CONSEC	OUENCE O	710	0.12 M	11/1	DAT	4	11				
CERTIFICATION	Sequentially list conditions,	b. DUE TO	OR AS A CONSEC	DIENCE O	TIC	010701	yo.	1-111	-/-	7-				
AT	If any, leading to immediate cause. Enter UNDERLYING	TDI	SPATI	2.1	•	/			-	′		j		
윤	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSEC	DUENCE O	f):							-		
E	resulting in death) LAST													
빙		d												
AL	PART II. Other significant condition	ns contributing to	daath but not r	esuiting	in the underl	ing cause giver	in Part	i. 24a. W		AUTOPSY	24b	MAILABLE PRIOR		8
DICAL								t 🗆 Y	YES 2	NO E		COMPLETION OF OF DEATH?		
A												t 🗌 YES 2 🗌	NO	
ä	DID TOBACCO USE	CONTRIBUT	E TO CAU	SE OI	F DEATH	YES 🔲	NO [
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	PLACE OF DEATH	(Check o	nly one)						
YSI	1 TYES 2 NO	1 - Inpetiant 2 \$	ER/Outpatient 3	□ DOA		lome 5 🗆 Resider	nce 6 🗆	Other (Specif	(y)					
표	27. MANNER OF DEATH t Natural 5 Pending	26a. DATE OF (Month, D		28b. TIN	JURY	INJURY AT WORK?		I. DESCRIBE I	HOW	INJURY OC	CURED			
B	2 Accident Investigation			<u> </u>		YES 2 NO								
ED	3 Suicide 6 Could not be 4 Homicide determined	28e, PLACE C building,	OF INJURY — At ho, atc. (Specify)	me, farm,	street, factory, o	ffica	261	City or Town,			or Aural i	Route Number,		
COMPLET	29a. CERTIFIER (Check only one)													
ő	2 MEDICAL EXAMIN	ER: On the beals of a	xamination and/or i	investigation	on, in my opinio	n, death occured at	the time	, data and pla	oca, ar	nd due to t	the cause(a) end manner as	stated.	
ш	29b. SIGNATURE AND THE OF CERTIFIE	20	no.	0		29c. LICENSE	NUMBER			29d. DA	TE SIGNE	D (Mogth, Day, Year	7)	
OB	Sun Di	Vanda,	9. M.	1		MDO	000	2595	5	1	1/11	2/97		
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAU	SE OF DEATH (ITE	М 27) (Туре	, Print)						1	1		
	2041 GEOV 912	AVE N.	SE OF DEATH (ITEI	1A51	1iN9te	N DC		200	62)				
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	AR'S SIGNATURE		P. 1.11									
	1112/1/ NOV	3 1997	your on	maria	rentall									

DHMH-16 Rev 1/89



aug physician s the burla 68760 gug Box P.O. signed by Records, certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completaly filled in by the funeral director,

Funeral

Director

the Marylend

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyler Department of Health and Mental Hygiene. Important if them 27 is marked other than "natural", or items 23a or 28a-1 show may injury or other traumatic event, the Mandala Examples the notified at

Physician /Medical

Examiner

8

Baltimore, Maryland 21215-0020

State

Registrar

YUSH

NOV 06 1997

29b. Signature end title of cartifier

31. Dete filed (Month, Day, Year)

MD.

29c. License number As-2441614-A-9

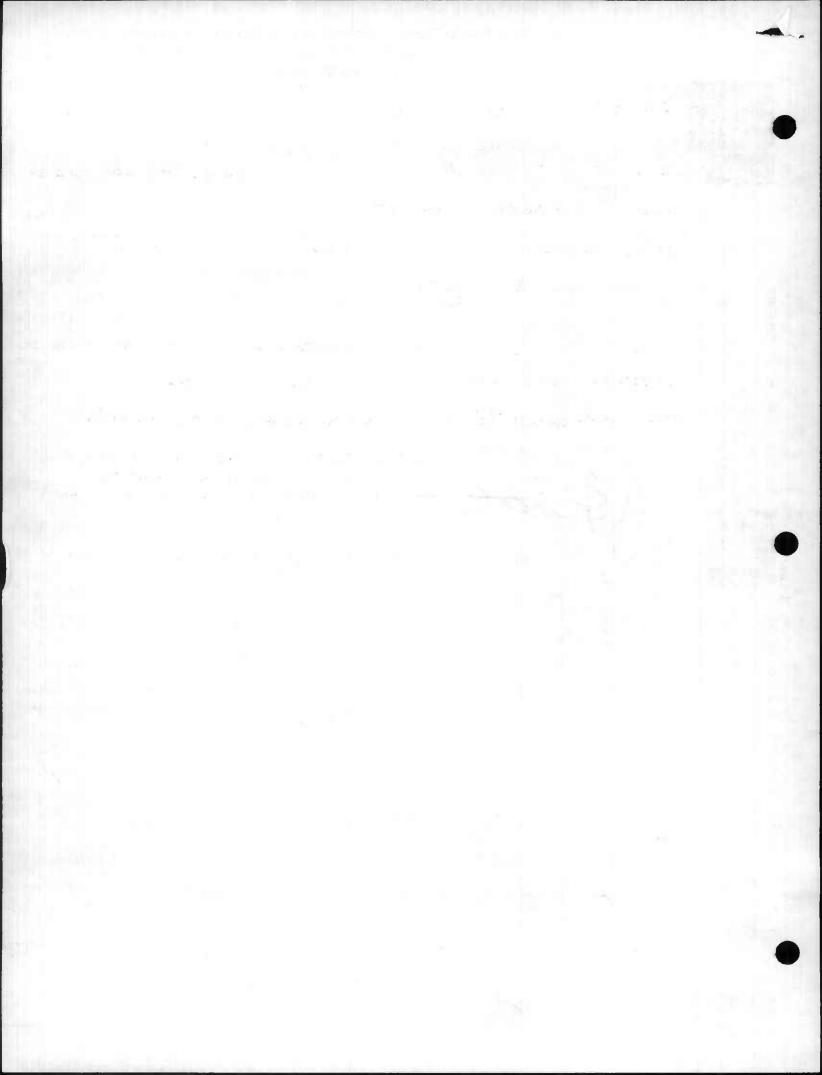
29d. Date signed (Month, Dey, Year) NOVEMBER

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

HARBOR

HOSPITAL

32. Registrar's Signature Julia Davidson



State of Maryland / Department of Health and Mental Hygiene 97 35776

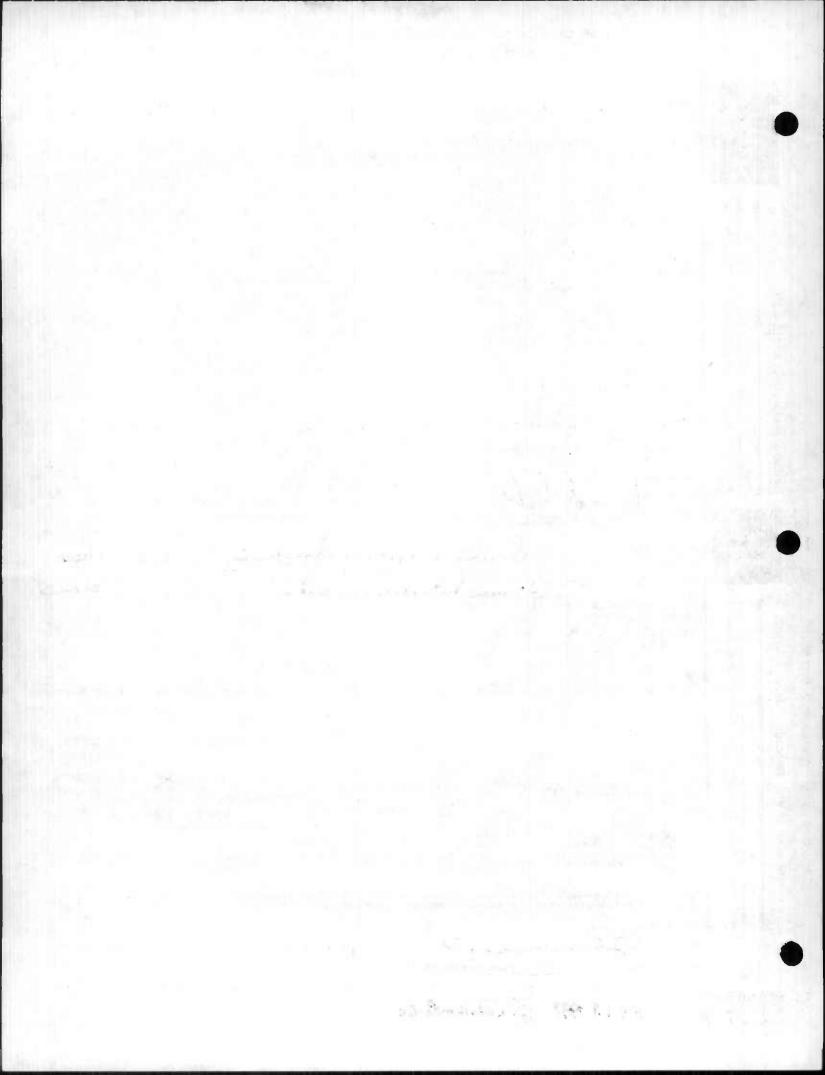
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_	Physic /Medi		Ernest	Gordon	1 1	aures				NOVEMB	BE 7	1997	9=30AM
	Exami		4e. Feditity Neme (If not institution, g	ive street and nu	nber)			4b.	City, Town, or L	ocation of Death	4c. Coun	ty of Deeth	
7			JOUTHERN 1	MARYU	AND	HOSF	TAL		CLIA	ITON	PRM	KE	GEERGES
ı	Funeral			Sex		last birthday	If Under 1		If Under 24 Hrs.	8. Dete of Bin	th		plece (Stete or Foreign
	Director		177-01-9908 Usuel Residence of Decedent	XXM 2□F	82	Yrs.	Months E	Deys	Hours Min.	8. Dete of Bir (Month, De May 15	, Year) 1915	Furn	nace Run, Pa
	and and		10a. Stete 10b. County		10c. C	ity, Town or Le	ocation			_			10d. Inside City Limits
	Aarylar f show	ō	Maryland Prince (Coorgo!s	100	okeek							1 ☐ Yes 2 ☐ No
	vith the Maryla or 28a-f shore	Directo	10e. Street and Number	corge 3	nec	.OKEEK	10f. Zip Co	ndo			10a Chinan a	S MATHER COLUMN	41
	72 hours after daath with the Maryland natural, or items 23a or 28a-f show ottal Examiner must be notified at	rai Dir	742 Farmington F				2060				10g. Citizan o USA	r whet Cou	ntry?
	daz m	Funeral	11. Merital Status	12. Wes Dece Armed Fo	edent Ever in U	J,S. 13.	Wes Deceden	t of Hisp	panic Origin? (Sp Mexican, Puerto	pecify Yes or No	14. Ra	ace - Ameri eck, White	
020	urs afte	þ	1 Never Merried 2 Married 3 Widowed 4 Divorced	WEW Voc	2 No re 1945 ates: 1945		1□ Yes 2□		Specify:	7 110411, 010.7		www. Whi	
Maryland 21215-0020	n 72 hour	Completed	15. Decedent's (Specify only highest g	Education		16a Dece	dent's Usuel C	Occupetion done duri	on ring most of work	king	16b. Kind of	Business/Ir	idustry
12	withii ane. than	E	Elementary/Şecondary (0-12)	Coilege (1	-4or 5+)						Dank	. c T	C D
2	filed within Hygiene. ther than of,	ပိ	17. Fether's Name (First, Middle, Las	.41		neavy	Equip		Operate				ans. forPa.
ano	should be filed and Mental Hyg marked other matic event,	Be	Ernest Davies	-					8. Mother's Nam		Maidan Sume	ame)	
2	ould be Mental arked o	2	Tillest Davies						Grace	Smart			
Jar	d 2 should th and Mei 7 is marke traumatic		19e. Informant's Neme/Reletionship	(Type, Print)		19b. Maili	ng Address (S	Street end	d Number or Ru	ral Route Numbe	er, City or Tow	n, Stete, Zi	p Code)
			Kelly Delaney/Dau	ghter		Same	as ite	em 10	0				
ore	T He de		20e. Method of Disposition	Y		Piece of Dispo	sition (Nema matory or othe	of er piece)		Dete	20c. Location	- City or T	own, Stete
Ĕ	Page Try o		1 Buriel 2 Cremetion 3	L2Hemovelmom:			's Ceme		y 1:	1/11/97	Ford C	itv.P	a.
altimore,	and and w		21. Signature of Funeral Service Lice	enspe		2:	2. Name and &	Address					
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			234 Part 1. Entar the disees a, or co	y one cours on e	ach line.	th. Do not an	er the mode o	x ayıng, :	such es carolac	or respiretory e	rest,	1	Approximate Intervei Batween Onset end Deeth
	Physician /Medical		Immediate Cause (Finel									1	
1	Examiner		disease or condition resulting in death)	e. >	eptic	- Sh	OCK					1	Admitted
		_				or as a conse	quence of):					1	on 10/27/97
П	pa is	Examiner		St. St	caphi	11000	ccarl	. R	acter	emila		i	Expired
	be axecuted ician and burial-transit	кап	Sequentially list conditions,		-	or es e consec	quence of):					1	cybines
90	cian ouria		Sequentielly list conditions, if eny, leading to immadiete cause. Enter Undarlying Ceuse (Diseese or Injury		Rena	1 Fa	ilore					1 1	24 11/2/21 We
68760	cate be ay physician s the buria	Medical	thet initieted events resulting in death) Last	G	Due to (or es e consec	uence of):					i	AT 9.30AM
	5 0 6	Me			oro	atul	Arto	~	Dises	. Y C		i '	1 1.301/11
Box	th ce	an		d		2035		-1-	13130			ì	-
	dea be att	Sici	Part II. Other significent conditions	contributing to de	ath but not res	sulting in the u	ndarlying caus	se given	In Pert I.	23b. Did 1	obacco use c	ontribute t	to the cause of death?
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of Vital Records,	v requires thet the death ce been signed by the attendi should be datached for use	Completed by Physician/	Insulin Depe Hypertension							24e. Was	an autopsy	24b. W	/ara autopsy findings vaileble prior to
8	sho sho	et	nypertension	•						perfo	rmed?	00	ompletion of cause
Re	e law has b	E											deeth?
a	Physician: The lathis certificate har director, page		Chronic Obs	Nuctive	- Lui	a D	isease	_		101	res 2 No	1	☐ Yes 2☐ No
===	Physician: this certific	Be	25. Was case rafarrad to medical examiner?	Linemite):					6. Place of Deal	th (Check only o	ne)		
70	Physical this of all directions of the second of the secon	2	1 Yes 2 No		patient 2	ER/Outpatier		Other:		oma 5 🗆 Rasio	dence 6 🗆 O	ther (Speci	(y)
2	ng P	Certification:	27. Manner of Deeth SNetural 5 ☐ Pending	28e. Dete d (Mont)	of Injury h, Dey Yeer)	28b. Time of Injury	28c.	Injury et Work?	t	28d. Describe I	now injury occu	urred	
.0	auth.	ati	2 ☐ Accident investigation	on			M	1 🗆 Yas	s 2 🗆 No				
Division	ar de	E E	3 Suicide 6 Could not determine	286. PIECE	of Injury - At h	ome, farm, str	eet, factory, of	ffice		28f. Location (S City or Tox		ber or Run	al Route Number,
Ö	s aft if Dir	Se		Donon	ig, etc. (Dpeci	· y /				Ony or 101	,,, 0,010,		
	splt hour nera y filli		29a. Certifier 1 Certifying P	hysician: To tha	best of my kno	wiedga, daeti	occurred at t	ha tima,	data end plece,	end due to the	ceuse(s) end n	nannar es s	stated.
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exa	miner: On the ba end mann	sis of axamina	ation end/or In	vestigation, in	my opini	ion, daeth occur	red et the time,	dete end plece	, and dua t	o the causa(s)
	Nithii To th	×	29b. Signetura and title of certifier				29c. Li	icanse ni	umber	4	29d. Date sign	ed (Month,	Day, Year)
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	112/	-		and the same	· · · · · · · · · · · · · · · · · · ·	1.17	Dalan	23	- 10			, , ,	1
	114/		30. Nama end eddress of person who	A A 1 1	or beeth (Itel	11 23e) (Type,	e D. A.	_ (Soile o	08 1.10	11-0	ME	7 20603.
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	Registr	ar	NOV 1 0 199	The state of the s	C BURUMAN	HI THE BELL							

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State of Maryland / Department of Health and Mental Hygiene 7 35777

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nan:		I. Decedent's Name (First, Mi									- 1	2. Dete of D Month		ev	Yeer	3. Time of	f th
icai	-	Dorothy Jean												10,	1997	7:02	ım
iner		a. Fecility Nema (If not institu								b. City, Town	, or Loc	ation of Dea	lh 4	c. County	of Deeth		
	-	Prince George	-							Chever			1	Princ	e Ge	orge's	
		579-56-2050		Sex 1□M 2⊠F	7. Age (In yn 75		thday) Yrs.	If Under Months	1 Yaar Deys	If Undar 24 Hours	Hrs. Min.	8. Dale of B Month, D May 7	ev. Yee	22	9. Birth Cou Sou	piaca (State o intry) th Dak	or Foreig ota
		Jsual Rasidence of Decedani 0a. State 10b. Cou			100.0	City, Town		alles									
5								MION								10d. Inside Ci	-
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State of Maryland / Department of Health and Mental Hygiene () 35778 Certificate of Death 2. Dete of Deeth 3. Time of Deeth Month

1 Yea 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

ANDREWS AIR FORCE BASE, MD 20762-6600

29d. Dete aigned (Month, Dey, Year)

NOVEMBER 09, 1997

Physician /Medical Examiner 1. Decedent's Neme (First, Middle, Last)

Funeral Director

the Maryland 7 is marked other than "natural", or items 23s or 28s-1 show traumatic svent, the Medical Examiner must be notified at 72 hours after permit. Pagas 1 and 2 should be filed within Departmant of Heelth and Mental Hygiena. Important: If itsm 27 is marked other than any Injury or other traumetic event, the Many Injury or other traumetic svent,
Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records.

Division of Vital

MAE

Physician /Medical Examiner

sician and burief-transit certificate be exec physician s the buriel 98 atten jo dateched the signed by t peed page 2 s cartificate To the Hospital or Attending Physician: within 24 hours effar death.

To the Funeral Director: After this cartific funaral 5

MAE AGNES DOUGLAS NOVEMBER 09, 1997 01:35 A.M. 4e. Feclity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth AMP SPRINGS PRINGS If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) MAY 1, 1910 MALCOLM GROW MEDICAL CENTER CAMP PRINCE GEORGE'S If Under 1 Yeer 5. Sociel Security Number 6. Sex 7. Age (In vrs. lest birthdev) 9. Birthpleca (State or Foreign Deys 1 M M MOXE Months 577-10-1837 87 Yrs WASHINGTON, DC Usuei Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD PRINCE GEORGE'S DISTRICT HEIGHTS Director 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? 7406 KIPLING PARKWAY 20747 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2000 No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 20No Specify: WHITE 2 3 Widowed 4 □ Divorcad Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working iffe. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be FULLER SYDNOR 2 EFFIE GRAY 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT C. DOUGLAS / SON 15302 GUNSMITH TERRACE WOODBRIDGE, VA 22191 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State METROPOLITAN CREMATORY 11-11-97 ALEXANDRIA, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenaee 22. Neme and Address of Fecility MARSHALL'S FUNERAL HOME OF MD 10 MUMULA 4308 SUITLAND RD. SUITLAND, MARYLAND 20746 23a. PertT. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, auch es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE UNKNOWN diseese or condition resulting in deeth) Due to (or es e consequence of) Examiner CORONARY ARTERY DISEASE UNKNOWN Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ₺ Unknown p 24b. Were autopsy findinga evalleble prior to 24e. Wes an eutopsy performed? Completed completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Wes case referred to medical 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☒ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident

State Registrar

31. Dete filed (Month, Dey, Yeer) NOV 12 1997

6 Could not be determined

3 Suicide

29e. Certifier

Medical

4 - Homicide

29b. Signeture end title of cartifier



28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as attedd.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 89 MDG/1050 W PERIMETER RD SUITE C1-7

29c. License number

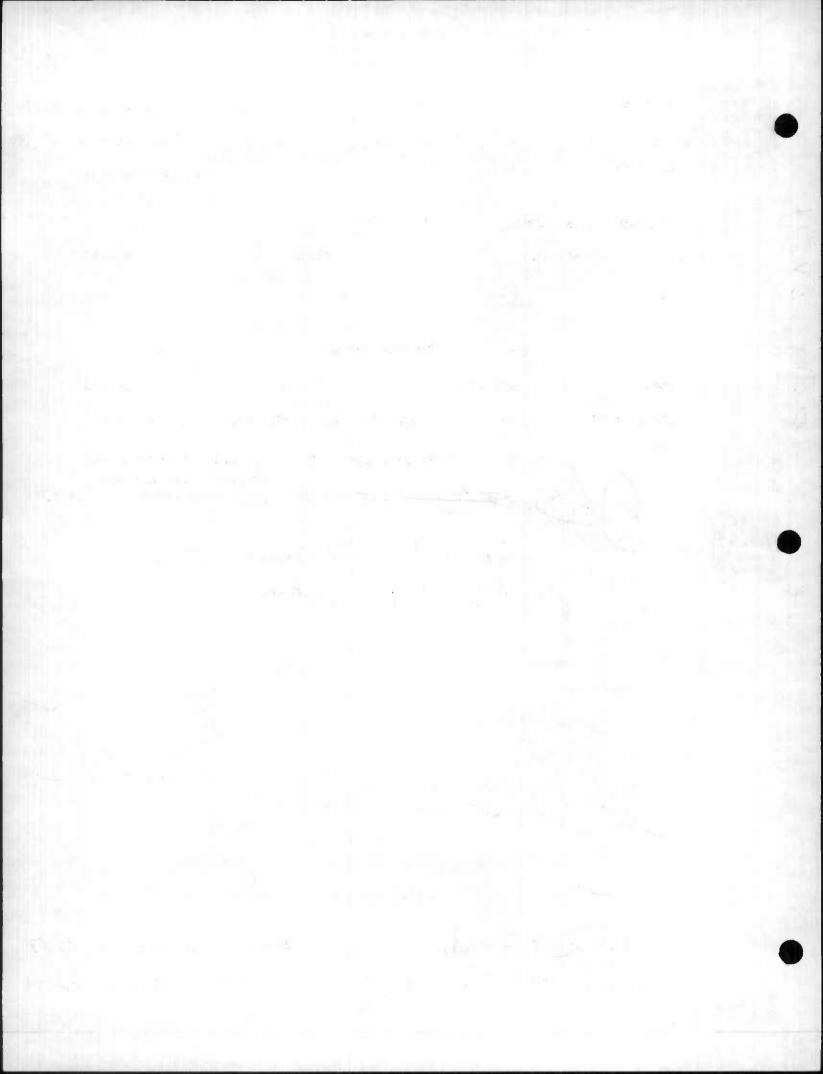
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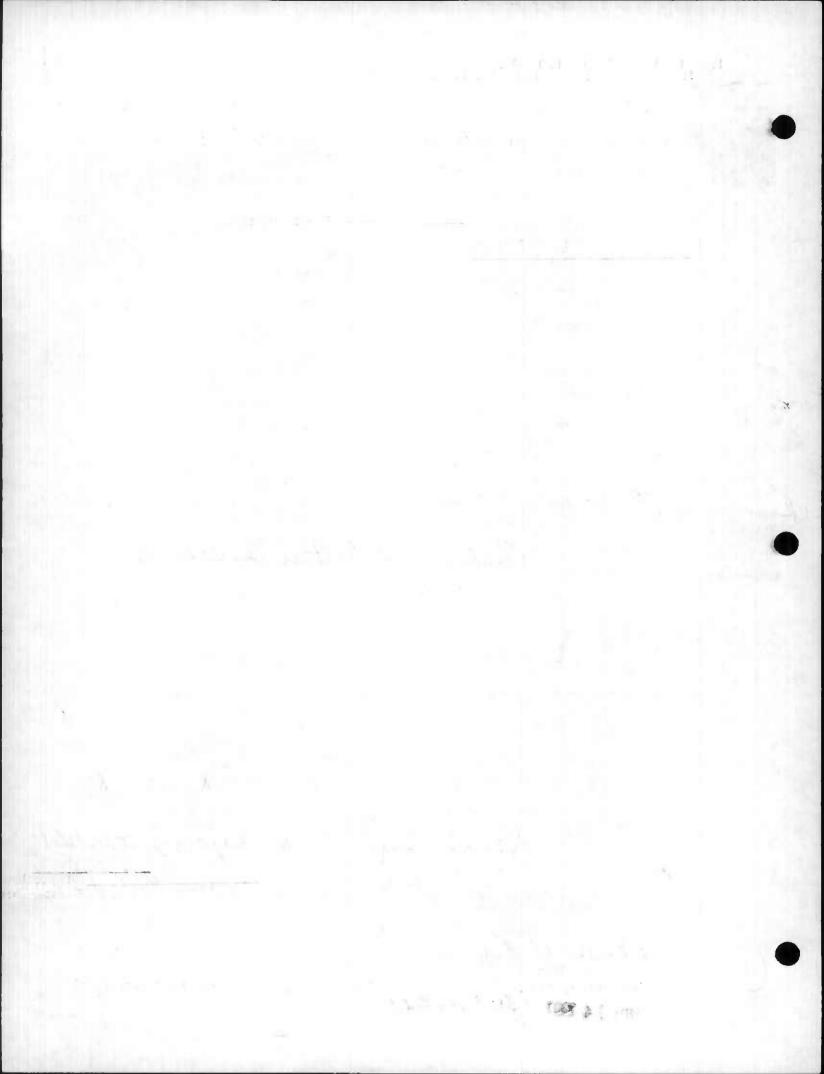


State of Maryland / Department of Health and Mental Hygiene

					Certifica	te of	Death		Reg. No.	1	32/80
Dhusis		1. Decedent's Neme (First, Middle, La	st)		15.77		1200	2. Dale of Dea	ath	Vaar	3. Time of Deeth
Physic /Medi		Esther	Frances	Fitzge	rald			Octobe	r 31	1997	1:35PM
Exami		4e. Facility Name (If not Institution, giv	e street and number)				4b. City, Town, or L	ocation of Death	4c. County	of Death	11 - 11
Funeral	r	25 Fitzgerald Ro 5. Sociel Security Number 6.8	ex 7. Age	(In yrs. last bir	Months	or 1 Yeer Deys	Annapoli If Under 24 Hrs. Hours Min.			9. Birthp	indel place (State or Foreign etry)
Director		Usuel Residence of Decedent		82	Yrs.			Aug 24		Virg	ginia
death with the Maryland ms 23a or 28a-f show	2	10e. State 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
the A	Director	MD Anne Ar	undel		Annap	olis p Code			40-00	10 . 0	
with with	Ö		,		10r. Z.				10g. Citizen of \		
leath	era	25 Fitzgerald R	0 ad 12. Was Decedent E	ver in U.S.	13 Wes Dece	214			United	State e - Americ	
permit. Pegas 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Health and Mentel Hygiane. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner mant be notified at page.	by Funeral	1 □ Never Married 2 □ Married 3 ₩ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Yeer or Dates:		If Yes, spe		dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White,	
72 ho	Completed	15. Decedent's Ed	ducation	16a.	Decedent's Usu	el Occup	petion		16b. Kind of Bi	usiness/inc	dustry
thin 6.	nple	(Specify only highest gre Elementery/Secondery (0-12)	College (1-4or 5-	+)	life. DO NOT	ise <i>retire</i>	during most of work d)	ang			
od w ygian t. In	S	12	3		Owner				Resta	urant	-
d oth	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Suman	10)	
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l 2 sh l and ls m		19e. Informent's Neme/Reletionship (1					end Number or Run				
Pegas 1 end nent of Health nt: if Itam 27 iny or other ti		Patricia C. Thal 20e. Method of Disposition **Pauriel 2					per Drive		College 20c. Location -		
Ped men		4 ☐ Donetion 5 ☐ Other (Specify	/)		nd Vete	rans	Cemetery		Crownsv	ille,	Maryland
permit. F Departmo Importan any injur		21. Signature of Eurieral Service Licen	2		22. Neme a	nd Addre	ss of Fecility John	M. Tay	lor Fun	eral	Home, Inc
		23a, Pert1. Enter the disease, or comp shock, or heart feilure. List only	olications thel caused one cause on each line	the death. Do r						OIIS,	Approximate Interval Between Onset and Deeth
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the at	Physician	Part II. Other significant conditions co	entributing to death but	not resulting in	the underlying	cause giv	en in Pert I.	23b. Did to	obacco usa coi	ntributs to	the cause of death
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Physician: this certific ral director,	2	101 103 25500	Hospitel: 1 Inpatien				4 LI Nuising Ho				1)
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To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29e. Certifier (Check only one) 1 Medical Example one)	relcian: To the best of iner: On the basis of e end manner state	exeminetion end	death occurred Vor Investigation	et the tin	ne, dete end placa, pinion, deeth occurr	end due to the c ed et the time, d	ause(s) end ma lete and pleca, a	nner as sta and due to	ated. the ceuse(s)
withi To the	X	29b. Signature and title of certifier			29	c. Licens	e number	2	9d. Date signed	1 (Month, E	Day, Year)
7		I South	Edu, MO			D30	0701		Novembe	er 3.	1997
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of Health item 27 r other t		20a. Method of Disp		70	come	a of Disposition (Na etery, crematory or	ame of other place)		Date	20c. Location	- City or To	wn, State
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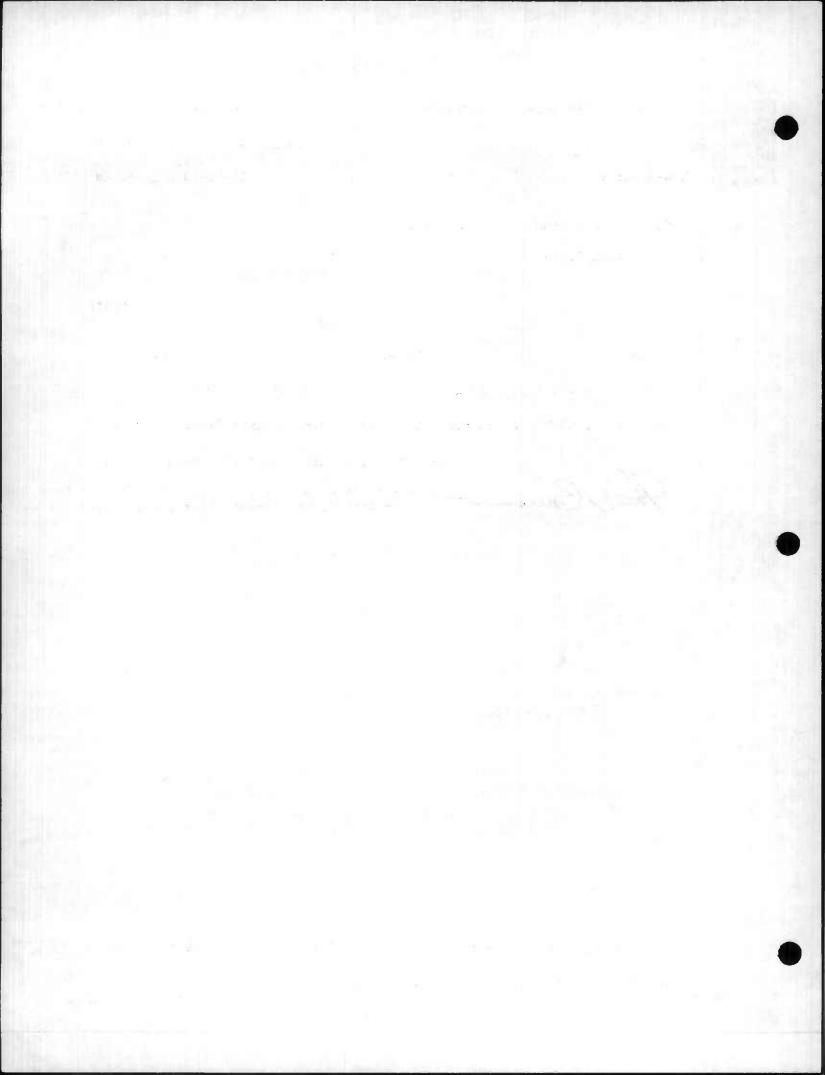
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Year .Iohn Robert Griffie 1997 October 30 12:45 PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Corsica Hills Nursing Home Centreville Queen Annes If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 52 yrs. **Funeral** Birthplece (State or Foreign Country) Months Deys 1XXM 2□ F Yrs. Director 216-44-7210 Mirch 28 1945 West Virginia Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Tyes XXNo Director Sudlersville Queen Annes 10e. Street and Number 10g. Citizen of Whet Country? death with 1016 Benton Corner Road 21668 United States Funeral then "natural", or items the Medical Examinar ma 12. Wes Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Stetus filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 XXNo If Yes, Give Yeer or Dates: 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) Heating & College (1-4or 5+) . Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If Item 27 Is marked other th Jury or other traumatic event, the 9 Technician Cooling Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Manuel Lee Griffie Nadine Inez Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21668 19e. Informant's Name/Retetionship (Type, Print) 1016 Benton Corner Road Sudlersville, Maryland Brenda Lee Griffie (Wife) 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Crematory 11/03/97 permit. Page Department of Important: If any Injury or once. 22. Name end Address of Fecility
John M. Taylor Funeral Home, Inc 21. Signeture of Funerel Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete **Physician** /Medical Immediete Ceuse (Finel LIVER METASTASES diseese or condition resulting in deeth) Examiner ADENOCARCINOMA OF LUNG-The law requires that the death certificete be executed Sequentietly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest P.O. Box 68760, Physician/Medicai the Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records. þ should be Completed 24b. Were eutopsy findings avelleble prior to completion of ceuse of deeth? 24e. Wes an autopsy performed? page 2 certificate 1 Yes 1 ☐ Yes 2 No Attanding Physician: Be 25. Was case referred to medicel exeminer? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Deeth 28b. Time of 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigetion 1 Netural 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end dua to the cause(s) and manner as stated.

2 Madicat Exeminar: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) (410-778-0200)30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Helen Noble, M.D. 122 Speer Road Suite 5 Chestertown, Maryland 21620 31. Date filed (Month, Day, Year) NOV 03 1997 32. Registrer's Signeture State hia Davidson-Randall Registrar

THE THE RESERVE TO SELECTED

					Ce	ertificate	e of	Death		R	eg. No.			
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/Medi Examii		4e. Facility Neme (If not Institution		umber)				4b. City, Tow		cation of Daath	4c. County			
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Funerai			1□M 2√2F		Vec	Months	Days		Min.	8. Deta of Birth (Month, Dey		9. Birthp Coun	try)	ate or Foreign
Director		238-01-6679 Usuel Residence of Decedent		83	7,00					11-10-1	3	N. C	arol	ina
pug *		10a. Stata 10b. County		10c Cit	ty, Town or L	ocation						1	Od Incle	le City Limits
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8a-f	oct		rundel	Sev	erna I									X
\$ 5 0 m	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	Whet Coun	try?	
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72 hours after death with the Maryland naturel; or items 23a or 28a-f show dical Examiner must be notified at	Funeral	11. Marital Status	12. Wes Dec	cedent Ever in U	,S. 13.	Wes Deced	ent of h	Hispenic Origi	in? (Spe	cify Yas or No- Ricen, etc.)		ce - Americ		n,
or h		1 Navar Married 2 Marrie	ed 1 ☐ Yes	2√ No		1 Yes 2			1 001101	110011, 010.)		ck, White,	HG.	
ours F	by	3√2 Widowed 4 □ Divorced	If Yes, G Yeer or I	Dates:		ILI Tes 2	NO LAG	Specify:			Specif	Whi	te	
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8 5 = 0		20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion	3 Removal from		cemetery, cre	metory or of	her pla	ce)	i	Date	20c. Location	- City or To	wn, Stat	8
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permit. Pege Depertment of Important: If any Injury or once.		21. Signature of Funeral Service I	icensee		2	2. Name end	d Addre	ess of Fecility						
88558		K/1/1/2	~							Severn				Home
-		23a. Fart1. Enter the diseese, or o	complications that	caused the deet	b Do not en	5 Rite	chi	e Hwy.	Sev	erna Pa	rk, MD	21,1	46 Approxi	lmata
		shock, or heart feilure. List of	aly one cause on	eech line.	50 1101 011	nai mo mode	o or ayı	ng, 3001 03 0	or digo o	respiratory arr	551,		Interval	Between and Deeth
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	lo	1⊅ENaturel 5 ☐ Pending	(Mor	th, Dey Year)	28b. Time of Injury		Bc. Injui			od. Describe no	w injury occur	red		
	cat	2 Accident investigation inves				М	1 🗆	Yes 2□N						
after deatl Director: In by the	=	4 Homicide determin	ed 286. Piece	e of Injury - At he ing, etc. (Specif		raet, factory,	office		2	8f. Location (St City or Town		ber or Rure	Routa	Vumber,
spital o	Certification:													
Hospital 24 hours Funeral letely filled		29a. Certifier 1 Certifying	Physician: To the	best of my kno	wladge, deat	h occurred e	t the tir	me, dete end	plece, e	nd due to tha ca	ause(s) end m	anner as st	ated.	
To the Hos within 24 h To the Fun completely	edicai	(Check only 2 Madical E	xaminer: On the b	esis of examina nner steted.	tion end/or In	vastigation,	in my c	pinlon, death	occurre	d at the time, de	ete and pieca,	end due to	the ceu	se(s)
within 2 To the comple	Me	29b. Signeture and title of certifiar			-	29c.	Licans	sa number		2	9d. Date signe	d (Month, I	Day, Yes	ar)
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		- Siller	-00 1	101			20	-1/	0			100)	111/
		30. Neme end eddress of person w	the completed ceu	se of deeth (Item	23e) (Type,	Print)		2000		1	00 -			1/0
		SURYA MU	NUCE	- Mp	203	C. P	67 (LANZE	0	14/5	131271	MUR	B	(1)
Sta	te	31. Dete filed (Month, Dey, Year)	32. F	Registrar's Signe	ture								21	221-



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth MARGARET HAMLIN Month 11 - Day ()3-Year) 7 **Physician** 20:20 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 169-03-8163 Yrs. 87 ,1910 Sharon, Pa. **Director** 29 Usuel Residence of Decedent 10a. Stete al Hygiene. other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Pa Allegheny Pittsburgh 1 X Yes 2 ☐ No Director 10e. Street end Number 7617 with the 10f. Zip Code 10g. Citizen of What Country? 15208 Baxter St. usa pemit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or Items 234 any Injury or other treumstic event, the Medical Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Rece - American Indian, Bleck, White, etc. 1 Naver Merried 2 Merried 1 ☐ Yes 2X No If Yes, Give 21215-0020 1 Yes 2 No Specify: Specify: Black þ lf Yes, Give Yeer or Detes: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10th Housewife DOMESTIC Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Joseph Lampkins Sadie lampkins 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dan E. Hamlin (son) 7617 Baxter st Pitts, Pa. 15208 20b. Plece of Disposition (Name of cemetery, crematory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Arlington Crematory 11-8-97 Arlington Va. 22. Name and Address of Facility STERLING FUNERAL SERVICE 21. Signeture of Funerel Service Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. 1601 Kenilworth Ave N.E. Wash.D.C.20019 Approximete Intarval Between Onset end Deeth **Physician** Immediete Causa (Finel diseese or condition resulting in deeth) /Medical Pneumonia Weeks Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed buriel-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated evants Due to (or as e consequence of): Box 68760. attending physician for use as the burie Physician/Medical thet initieted evants resulting in death) Last Due to (or es e consequence of): signed by the at id be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown RENAL FAILURE P 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed CONGESTIVE HEART FAILURE peen hes 1 Tes 20 No 1 ☐ Yes 2 ☐ No certificate f or Attending Physician: after death. Director: After this certifica funeral director, 25. Wes casa referred to madical exeminer? Be 28. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2♥ No P 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Panding 1 ☐ Yes 2 ☐ No investigetion the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Pleca of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 5 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled I edical ↑ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, data and plece, and due to the cause(s) end menner stated. 29a. Certifier 29b. Signature and little of certifie 29c. License number 29d. Dete signed (Month, Day, Year) D23911 11-04-97 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) DAVID A. BLASS MD. 9410 OLD GEORGETOWN RD. BETHESDA, MD. 20814 Registrer's Signeture 31. Dete filed (Month, Day, Year) State all Sander Randell

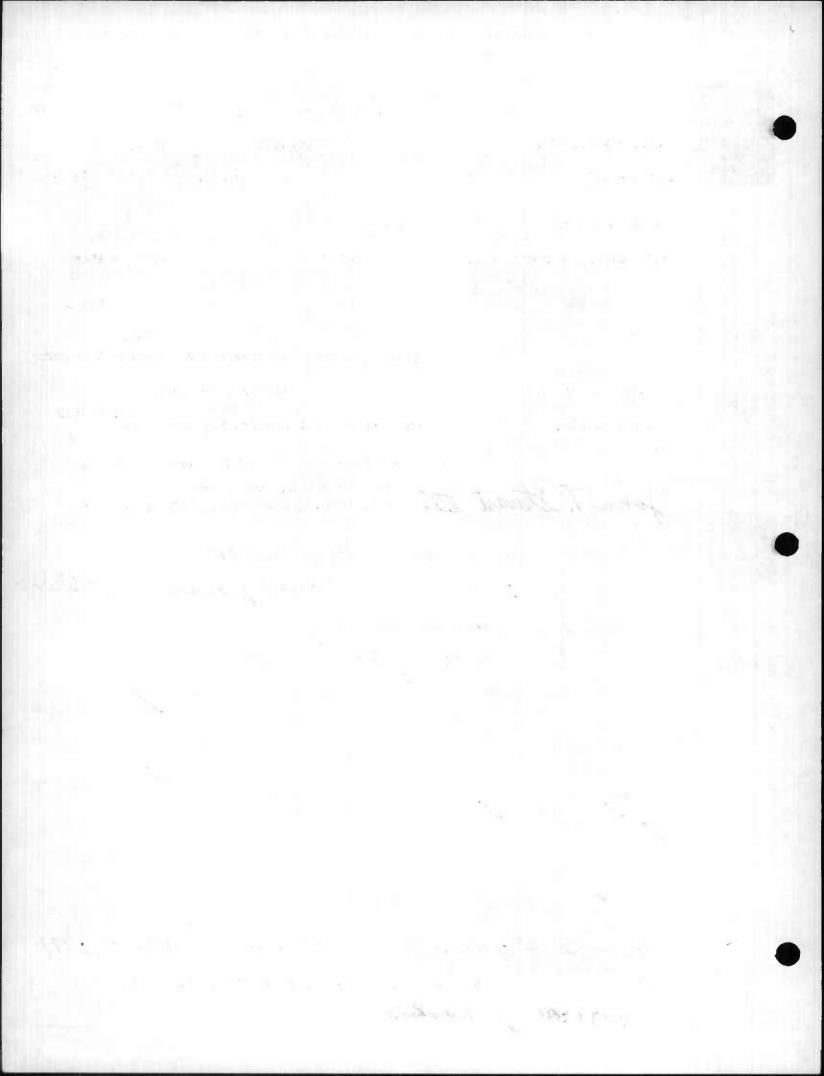
DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene

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ian		1. Decedent's Name (First, Mi	ddle, La		,		4.15	1/		2. Date	of Deat	th Day	Year	3. Time of Death
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ner	4	la. Facility Nama (If not institu	tion, giv	e street and i	number)				4b. City, Town	, or Location o	Death	4c. County	of Death	h
		SUBURBAN HOS	-						Bethe			Mont		
	5	5. Social Sacurity Number	6. 5	Sax IXIM 2□ F	E .	(In yrs. last birtl	nday) If Under Months	Days		Min. (Mo	of Birth	, Year)	9. Birth	nptaca (State or Forei
	1	110-44-4250 Usual Residence of Decedent		43				4	Aug.	11,_	1954	Nash	ville, Tenn.	
	10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limit			
ğ	١,	Maryland Montgo		Bethesda								1 ☑ Yes 2 ☐ N		
by Funeral Director	1	Maryland Montgomery 10e. Street and Number					10f. Zip Code				10g. Citizen of What Country?			
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	1	11. Marital Status		12. Was De	ecedent Ev	rar In U,S.			·	? (Specify Yes	or No-	14. Rac	ce - Amai	rican Indian,
F		1 ☐ Nevar Married 2 ☐ Marriad		Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			1 U.S. 13. Was Decedent of Hispanic Origin? (Spit Yas, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:				(C.)		ck, White	e, etc.
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Co	-			2	2	Com	munity .	Act:						Comm. Ctr
Be		17. Father's Name (First, Midd)			18. Mother's Name				e (First, Middle, Meiden Surna			ime)	
2		John H. H							Mi	nnie L.	L. Walston ute Number, City or Town, State Zin Code) 20008-5633			
	1	19a. Informent's Name/Retation			Print)		Mailing Address	s (Stree	et end Number	or Rural Route	Number	r, City or Town,	2000	8-5633
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DHMH 16 Rev 6/95



Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Items: 23 part I, II, per MEO G-755 1/2/98 reb Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day **Physician** Month FRANK DANIEL HACKLEY NOVEMBER 07, 1997 1754 P /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Clinton 7808 PINEWOOD DR. PRINCE GEORGES | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 9. Birthplace (State or Foreign Country) | April 27, 1949 | WashingtonD. 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 □ F 577-66-9474 48 Yrs. Director Usuai Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Med cal Examinar must be notified at 1 Yes 2 No Maryland Prince George Clinton Directo 10e. Straet and Numbar 10f. Zip Code 10g. Citizan of What Country? 7808 Pinewood Drive 20735 USA death Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? 14. Raca - American Indian, Biack, White, etc. 13. Was Dacedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on the Mental Hygiena.

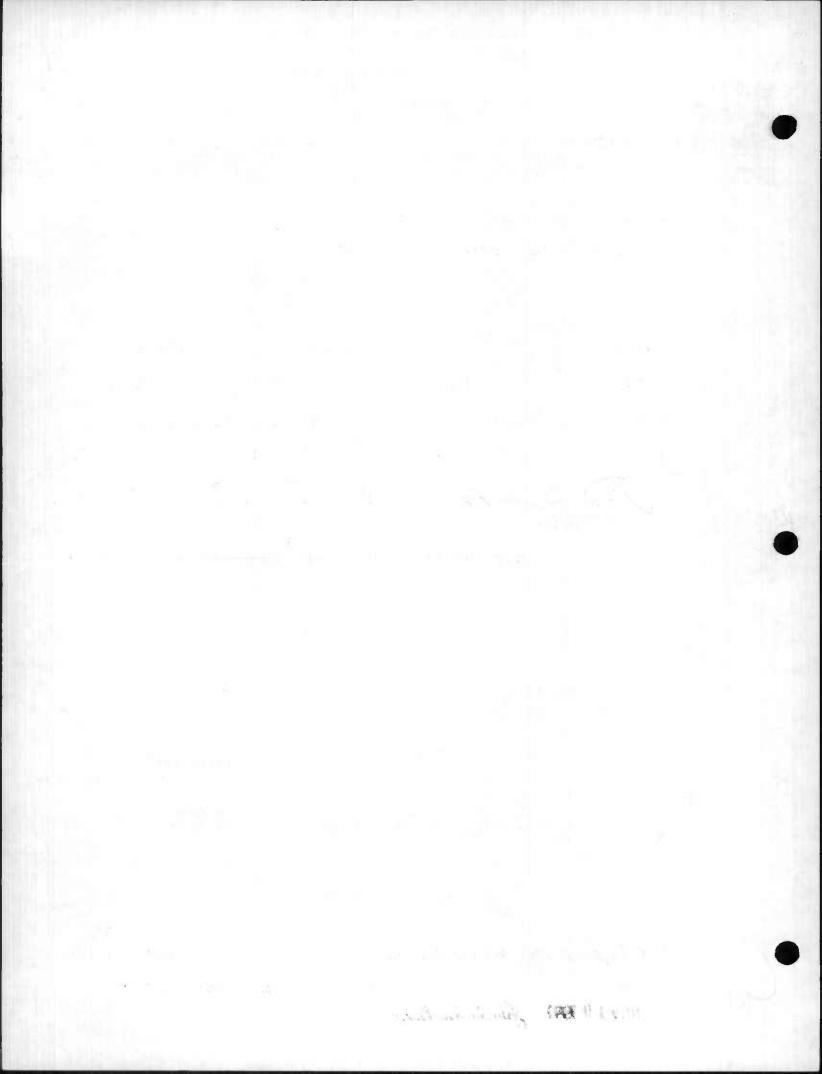
Is marked other than "natural", or ital 1X Yes 2 No If Yes, Give 1971 Yaar or Datas: 1971 1 X Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Black by 3 ☐ Widowed 4 ☐ Divorced 1972 Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Coilege (1-4or 5+) Policeman Government. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be George Hackley Darcus Hill 19e. Informent's Name/Relationship (Typa, Print) 19b. Meiling Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 Department of Health e Important: if Itam 27 Is any injury or other tras Gordon A. Hackley (Brother) 4416 Reamy Dr., (Suitland, Md. 20746) 20b. Piaca of Disposition (Nama of cametary, cramatory or other placa)

Ft. Lincoln Cemetery 11/12/ Brentwood, Md. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 □Other (Specify) 22. Name and Address of Facility
Jordan Funeral Service, Inc. 4001 Benning Rd., N.E. (Wash., D.C. 20019) 23a. Parti. Enter the disease, or control promis that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** DIABETIC KETOACIDOSIS /Medical Immediate Ceuse (Final disease or condition resulting in death) a Hypertensive atherosetrophe Cardiovascula Examiner Due to (or as a consequence of): Examiner physicien end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) 50 attending 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the detached 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen Inspected has certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 XYes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) pletaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the ceuse(s) and mannar stated. 29b. Signature and title of certified 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) OCME NOVEMBER 08, 1997 0 2 adrniz 111 Penn Street, Baltimore, Maryland 21201 Stephen 5.

32. Registrar's Signature

State Registrar 31. Dete filed (Month, Day, Yaar) NOV 10 1997

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema /First Middle Last 2. Date of Deeth 3. Time of Death **Physician** Month 05:26 AM NOVEMBER 08, 1997 RAYMOND HAWKINS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MARYLAND HOSPITAL CENTER SOUTHERN CLINTON PRINCE GEORGES Hours Min. 8. Date of Birth (Month, Day, Year, JUNE 22 21 5. Social Security Number If Under 1 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 9. Birthpleca (Stete or Foreign **Funeral** Days Yre WASHINGTON DC 579-16-0746 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits ral', or items 23a or 28a-f show Examiner rural be notified at ¥☐ Yes 2☐ No Directo PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH 8907 DANGERFIELD PLACE 20735 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forces? ★□ Yas 2 □ No If Yes, Give Year or Detes: Rece - American Indian, Bieck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Pages 1 and 2 should be filed within 72 hours after of and of Health and Mental Hyglene.
Int: If Item 27 Is marked other than "natural", or item
INY or other traumatic event, fre Medical Examinar
INY or other traumatic event, fre Medical Examina 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) DRIVER FED GOVERNMENT 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MARTE LEWIS JOSEPH C. HAWKINS 19e. tnforment's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5004 2nd ST N.W. WASHINGTON DC 20011 STANLIE BARTON 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Department Department Important: If any Injury or once. QUANTICO NATIONAL CEMETERY11-14-97 QUANTICO VA 22. Name and Address of Exampler S. POPE FUNERAL HOME 21. Signatura of Junaral Service Licensee 5538 MARLBORO PIKE FORESTVILLE MD 20747 23s. Part1. Enter the diseasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** tmmediate Ceuse (Finel disaase or condition rasulting in death) /Medical . HYPERTENSIVE ARTEKIOSCUEROTIC CARPIOVASCULAR DISEASE Examiner Due to (or es a consequence of) Examine ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that in its description) Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical thet initieted events resulting in deeth) Lest Dua to (or es e consequence of): USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed I Records. þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was en autopsy page 2 2 No 1 ☐ Yas 1 TYes 2 No of Vital 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To 1 Yes 2 No funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending Investigation daath. 1 Yes 2 No 2 Accident the 24 hours after daat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled In by 4 Homicide Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as stated. Medicai tely Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and marrier and marrier and the course of the c (Check only one) To the Within 2.
To the Complete 29c. Licensa number 29d. Dete signed (Month, Dey, Year) DIME NOVEMBER 08, 1997

State Registrar

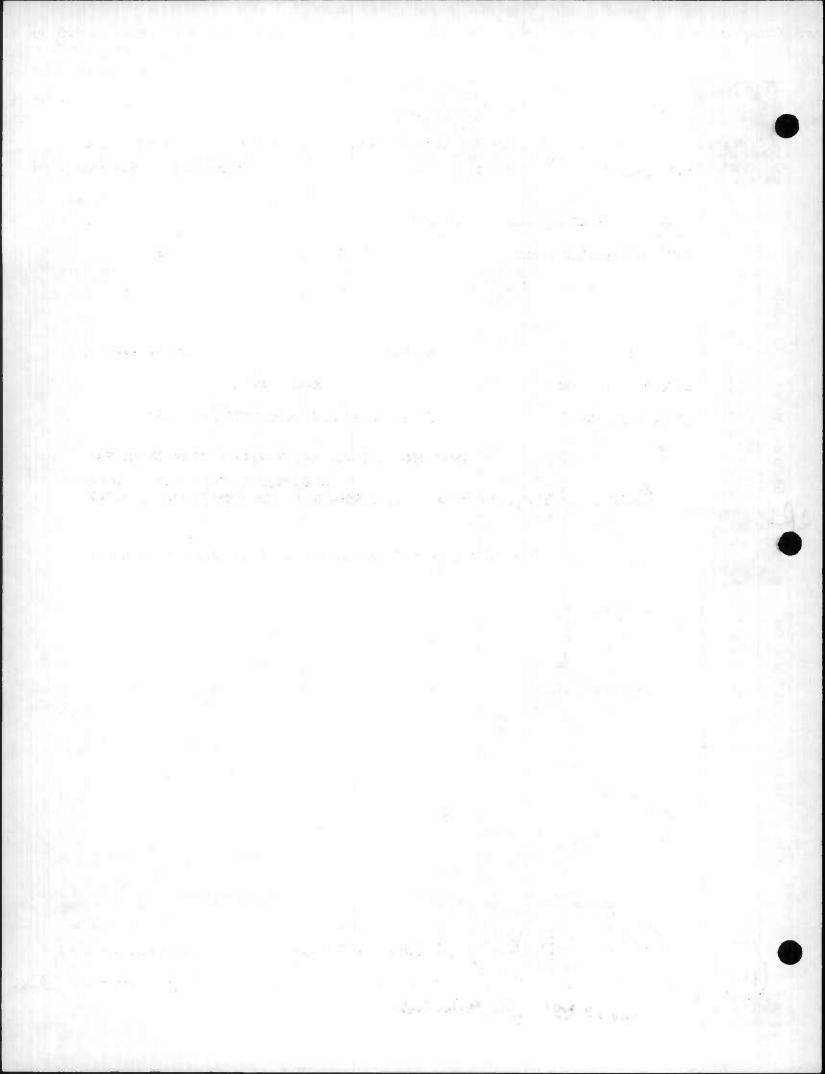
MARIO

31. Date filed (Month, Dey, Year)

NOV 13 1997

HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 MD GOLLE 3001 37 Register's Signeture

30. Name end eddress of person who completed cause of yearh (Item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** Month MAE L. HALL -9711-/Medical 6 11:15 pm 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 8918 FAIRVIEW AVE. LANHAM PRINCE GEORGE'S 5. Sociel Security Number If Under 1 Year 7. Aga (In yrs. lest birthday) If Undar 24 Hrs. **Funeral** 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) Hours 578-26-8622 1 M 2 F 78 Months Days Director APRIL 13,1919 WASHINGTON DC Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Insida City Limits r than "natural", or items 23a or 28a-f shorths Medical Examiner must be notified at Yas 2 No Director MD PRINCE GEORGES **T.ANHAM** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8918 FAIRVIEW AVE 20704 USA death Funeral 12. Was Dacedent Ever in U.S. 11 Marital Status Was Dacedant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yas 2 No
If Yes, Give filed within 72 hours aftar 1 Navar Marriad 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0020 Specify: BLACK à 3 Widowed 4 □ Divorced "natural", Year or Dates Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiane. Eiementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER PRIVATE permit. Pages 1 and 2 should be filed Department of Heelth and Mental Hyg Important: If Nem 27 Is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumema) Be JAMES A. PROCTOR ROSETTA NEWMAN 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) NEDIA HALL /DAUGHTER 8918 FAIRVIEW AVE LANHAM MD 20704 Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Buriel 2 Cremetion 3 Removal from State HARMONY MEM PARK 11-12-97 LANDOVER MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licenses 22. Name end Address of Fecility ALEXANDER S. POPE FUNERAL HOMES Source = 04/085 5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Daath **Physician** /Medical Immediate Cause (Final 2 YEARS METASTATIC BLADDER CANCER disease or condition resulting in death) Examiner Due to (or es e consequença of) Examiner sician and bunal-transit be executed Sequentially list conditions, if eny, leading to Immediate causa. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es e consequence ot) ng physician a Box 68760 Physician/Medical Dua to (or as a consequence of): attending esn signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? O Yes 2 No 3 Probably 4 Unknown CHRONIC OCSTRUCTIVE PULMONARY DISEASE by Records, should 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy performad? pega 2 1 ☐ Yes 2 No certificata 1 ☐ Yes 2 No Division of Vital Attending Physician: director, 25. Was case refarred to medical Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatlant 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending or Attending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stefa) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral D Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie pletaly (Check only one) To the To the To the Complet 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) selje M. D D - 33482NOVEMBER 7,1997

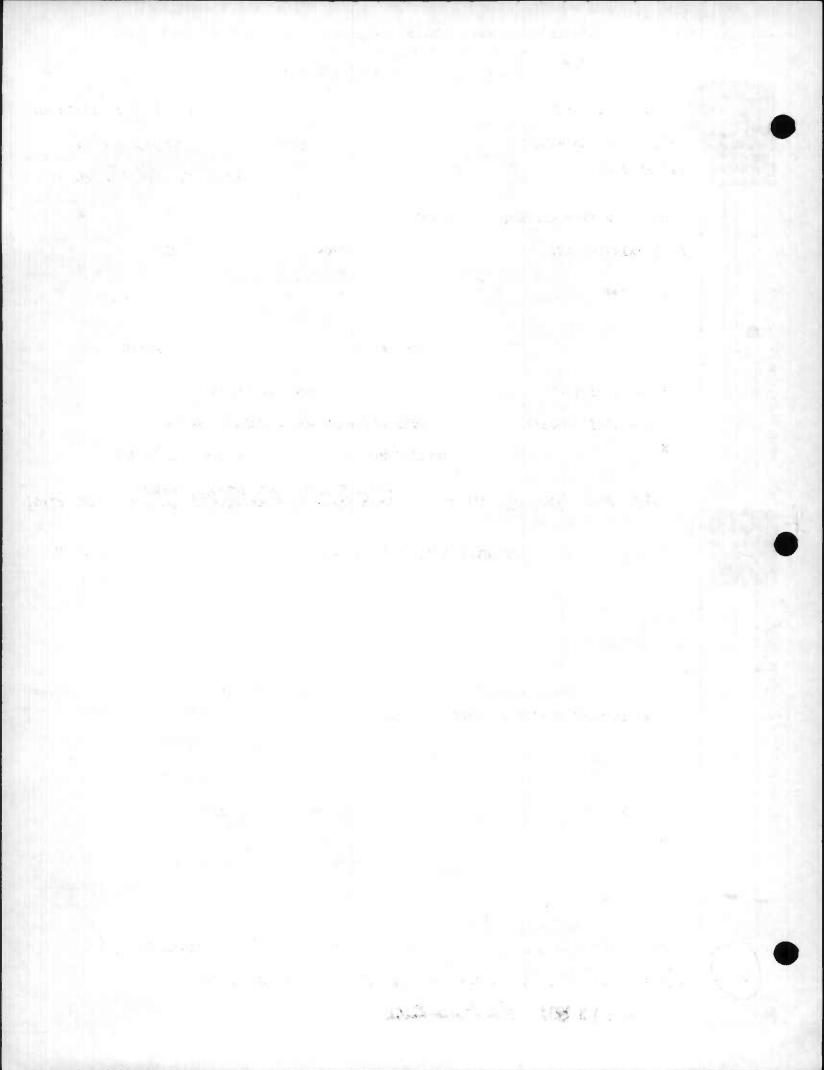
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32 Registrar's Signature NOV 13 1997 Jan Davder Radell

SAJEER ANAND M.D. 7343-A HANOVER PARKWAY, GREENBELT MD 20770

30. Neme and address of person who completed cause ot deeth (item 23e) (Type, Print)

State Registrar



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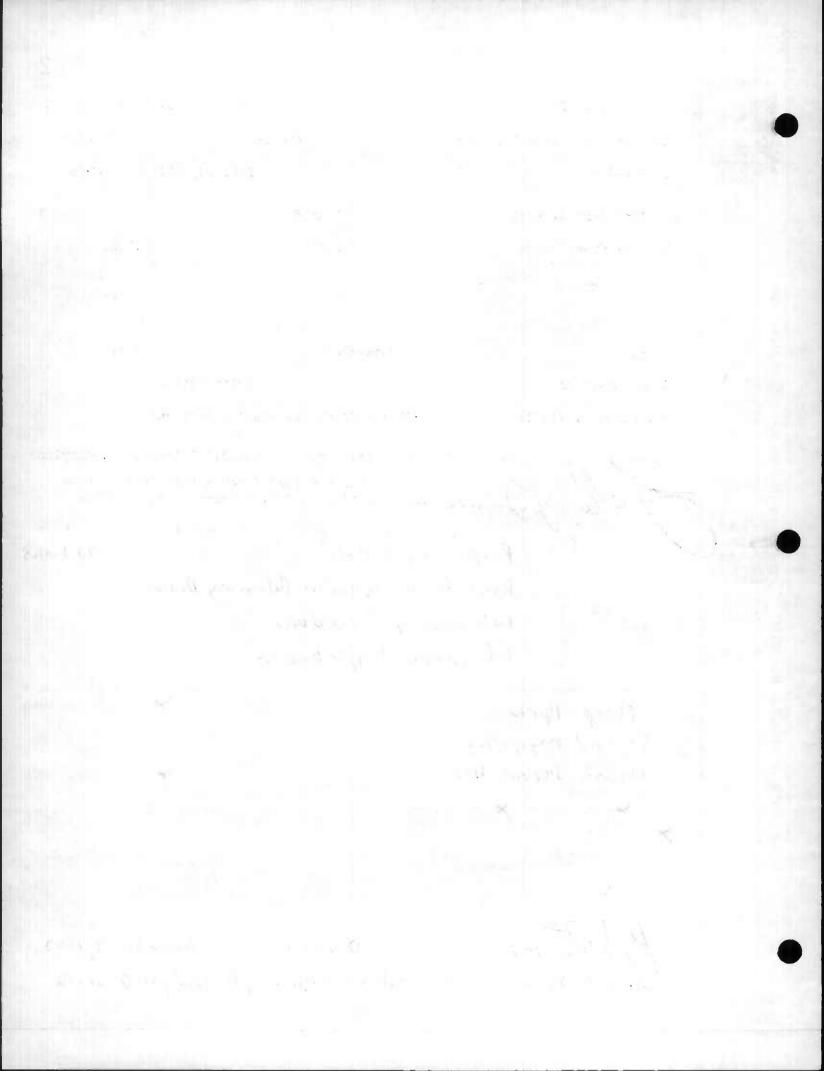
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Day November 3, 1997 **Physician** 9:15PM Anne L. Kiefler /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel H Under 24 Hrs. 8. Dale of Birth Hours Min. (Month, Day, Year) 5. Social Security Number # Under 1 Year 7. Age (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) **Funeral** 1 M 2 F Days Yrs. 66 Director Feb. 16, 1931 281-28-2390 Ohio Usual Residence of Decedent with the Marylend 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Modical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inalde City Limits 1 ☐ Yes 2 🗓 No Director Arnold Maryland Anne Arundel 10e. Straet and Number 10g. Citizen of What Country? 10f. Zip Code 21012 U.S.A. 509 Bay Green Drive Funeral 11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 ☐ Yes 2 No It Yes, Give Year or Detes: 1 Never Married 20XMarried Baltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit, Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens, imperant if flem 27 is marked other than "ne any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Auckerman Louise Merle 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 509 Bay Green Dr. Arnold, Maryland 21012 Mr. Glenn M. Kiefler 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MBurial 2 Cremation 3 Removal from State 4 ☐ Donation → Other (Specify) Hillcrest Cemetery Nov. 7, '97 Annapolis, Maryland 2) Signature of Funeral Sovicy Ligens 22. Name and Address of Facility
Barranco & Sons Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 Paul. Enter the disease, or compact current hat caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shack, or heart tailure. List only are cause on each line. Physician /Medical ediate Cause (Finel Respiratory failure 72 hours disease or condition resulting in death) Severe Chronic Obstructive Pulmonary Discove
Due to (or as a consequence ot): Examiner physician end s the burief-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Sar wid osia Physician/Medical Hyper Kension Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown sleep Aprea Division of Vital Records, Completed by 24b. Were eutopsy tindings availabla prior to completion of ceusa of death? Steroid my opothy 24a. Was an autopsy performed' Chronic Steroid Use 1 Yes 2 10 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certificalete filled in by the funeral director, 25. Was cese referred to medicel exeminer?
1 ☐ Yes 2 → No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner ot Deeth 28b. Time of Injury 28c. tnjury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel 2 Accident 1 Yes 2 No 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28e. Place of Injury - Al home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 DCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner steted. To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of continue 29c. License number 29d. Data signed (Month, Day, Year) November 4, 1997 mo 032654 and inddress of person who completed cause of deeth (Item 23a) (Type, Print) Serlemitsus Ritchie Highway, Arnold, mo 1509 John 31. Dete filed (Month, Dey, Year) NOV 06 32. Registrar's Signeture State Julia Davidson Mandelle Registrar



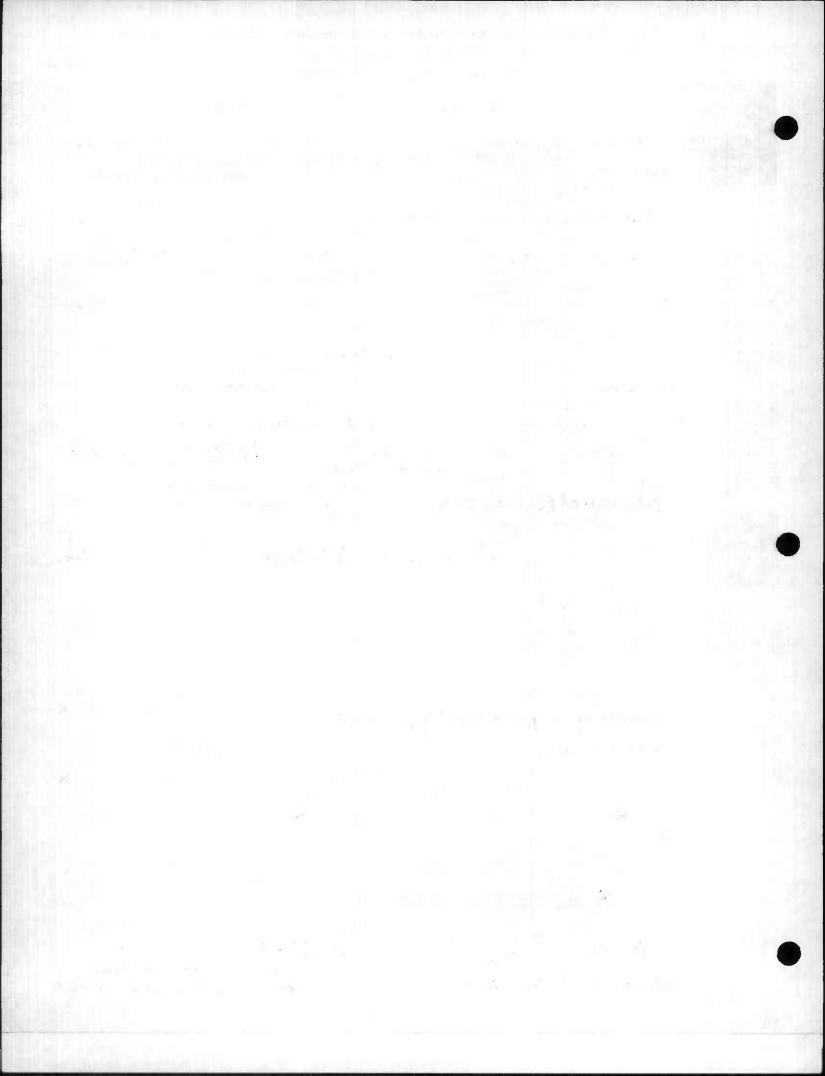
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** October 22, 1997 Sidney I Kazares 12:50 AM /Medicai 4a. Facility Nama (If not Institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health of Kensington Kensington Montgomery County 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Yrs. Director 164-10-0603 91 July 4, 1906 Russia Usual Residence of Decedant with the Marylend 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Evansiver inval be notified at Maryland Montgomery County Germantown 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? United States of America 11218 Winding Brooks Lane 20876 deeth 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mentel Hygiene. Important: If flem 27 Is marked other than "natural", or Hen any injury or other treumatic event, the Medical Express 1 ☐ Yas 2 🕅 No If Yes, Give Year or Dates: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Owner/Operator Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Max Kazares Essie Orenstein 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20876 19a. Informant's Name/Ralationship (Type, Print) 11218 Winding Brooks Lane, Germantown, Maryland Richard Kazares/ Son October North Lauderdale 20b. Piaca of Disposition (Name of cemetary, cremetory or other place)
Star of David 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 27,1997 Florida Memorial Gardens 21. Signatore of Funerel Service Licensea 22. Name and Address of Facility
Star of David Memorial Chapel #M00690 Causas 7701 Bailey Road, North Lauderdale, FL 33068 23a. Part1. Enter the diseasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heer feiture. List only one causa on each line. Approximete Interval Between **Physician** /Medical Immadiate Cause (Final PROGRESSIVE DEMENSIA disease or condition resulting in death) 4 GARS Examiner Due to (or es e consequença of) hysician end the buriel-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): eftending physician for use es the burie certificete be Physician/Medical Due to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably € Unknown MYOCARDOPATHY. Records, by 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Wes an autopsy performed? Completed peen INANITION s certificate has b director, page 2 s 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital 25. Wes cese referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 1 Natural 2 Accident 5 Pending Hospital or Attending 24 hours after death.
 Funeral Director: After 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physicien: To tha best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 08944 3720 FARAGUT NE. KENSINGTON, MD-20895 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) G.M. MARTIN C. SHARGEL 32. Registrar's Signeture 31. Date filed (Month, Day, Year) -State Julia Davidson

DHMH 16 Rev 6/95

Registrar

NOV 0 4 1997



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 1 1 - 05 - 1997 2:40 AM KEMPER TESSIE **ETTA** /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SEVERN ANNE ARUNDEL 526 TEPPER ROAD If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 4-19-1909 7. Age (In yrs. lest birthday) 9. Birthplace (Steta or Foreign **Funeral** 1□M 2\ F Days Hours MARYLAND Director 88 Yrs. 212-70-2955 Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at Director t ☐ Yes Ž☐ No MARYLAND ANNE ARUNDEL SEVERN 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 238 526 TEPPER ROAD 21144 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours efter death items : 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 Ď No If Yes, Giva Yeer or Dates: 11. Meritei Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 21215-0020 ŏ 1 ☐ Yas 2 No Specify: þ Specify: 3 1 Widowed 4 □ Divorced WHITE "naturel", Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "na any Injury or other treumetric. Elemantary/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 8 YEARS Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumema) Be ETTA HARDAGAN EARL EYLER 19e. Informant'e Neme/Raletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) 9 HANDFORD DRIVE HARMANS, MARYLAND SHIRLEY A. ROTHGEB (DAUGHTER) 20b. Plece of Disposition (Neme of cemetery, cramatory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removal from State GLEN HAVEN MEMORIAL PK. 11-8-97 GLEN BURNIE, MARYLAND 4 ☐ Donetlon 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Ligensee 22. Neme end Address of Fecility THE SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061 23a. Pert1. Enter the disees shock, or heart ailure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, only one cause on each line. Onset and Deeth **Physician** /Medical Immediete Cause (Final diseese or condition resulting in deeth) **Examiner** Examiner The law requires that the death certificate be executed the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last Due to (or es e consequence of): ettending physician for use as the buria Box 68760 Physician/Medical Due to (or es e consequence of) P.O. ed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? signed by ti 1 Yes No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes an autopsy parformed? peen this certificate Division of Vital or Attending Physicien: 25. Was cese referred to medical examiner? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral Certification: Menyrer of D 28a. Date of Injury (Month, Day) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After Netural 2 Accident 5 Pending investigation death. 1 Yes 2 No after death filled in by the 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D completely filled Certifying Physician: To the bast of my knowledge, death occurred et the time, date end piece, end due to the causa(s) end manner as stated.

Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the causa(s) end menner steted. Medical 29s. Certifi the 29b. Sign of certifian 29c. License number 29d. Dete signed, (Month, Day, Yeer) and address of parson who completed cause of death (Item 23a) (Tyr 38 GREEN TREE DEATH

DHMH 16 Rev 6/95

State

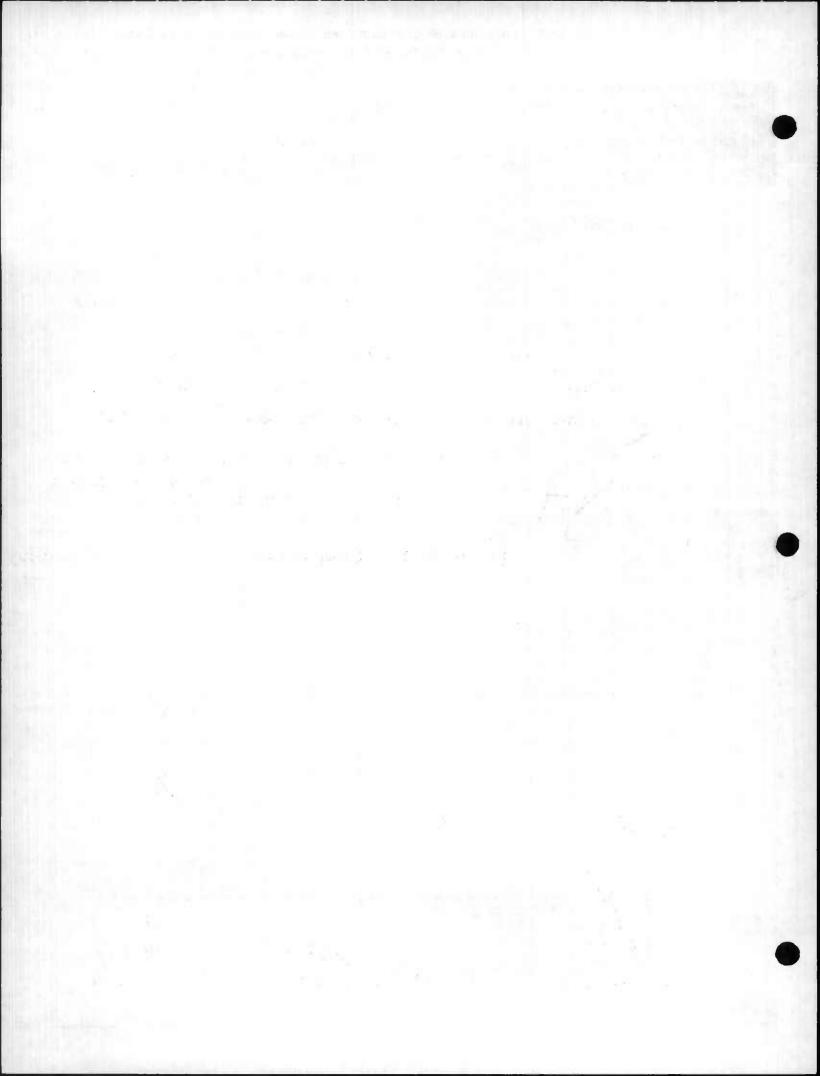
Registrar

31. Date filed (Month, Day, Year)

NOV 06 1997

32. Registrer's Signeture

ulia Davidsor



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 3. Time of Deeth 2. Dete of Deeth Month : == 4 **Physician** ERUIN 10 KENHEDI 00 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 8. Dete of Birth (Month, Dey, Year) XXM 2DF 243-01-7975 Yrs. Director 21, 1916 Lenoir County, NO Jan. Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits man be notified at X₩ Yes 2 No Director Maryland Prince George Adelphi 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1801 Metzerott 20783 Funeral United States daath 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Dates: r then "natural", or items 13. Wes Decadent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 💢 No Specify: by 3₺ Widowed 4 Divorcad Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Bricklayer/Painter Home Improvement 6th other t traumatic event. 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked other any lightry or other traumatic event 2008. 18. Mother's Name (First, Middle, Meiden Sumeme) Anthony Thomas Kennedy Annie Lee Williams 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Maggie C. McLawhorn Neice 12302 Rockledge Dr. Bowie, Maryland 20715
of Disposition (Neme of Date 200. Location - City or Town, State 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) *Burial 2 Cremetlon 3 Removal from Stete Glenwood Cemetery 11/8/97 4 Donetion 5 Dother (Specify) Washington, DC 22. Name end Address of Fecility Latney's Funeral Home, Inc. 3831 Georgia Ave, NW Washington, DC 20011 Enter the disease, or complications that eached the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) **Examiner** Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest physicien and the buriel-tren Due to (or es e consequença of): be exec 2 Q V Box 68760 Diabeter Physician/Medical Due to (or es e consequenca of) attending ed by the atten detached for u Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? rock und 1 Yee 2 No 3 Probably 4 Unknown signed I Records. þ 24b. Were autopsy findings available prior to completion of cause of death? been si 24e. Wes en autopsy performed? Completed 1 ☐ Yes 2 No Division of Vital Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 20 After this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Attanding 5 Pending Investigation Injury 1 Naturel Sat 9 97 death. 1 Yes 2 No 2 Accident work 28f. Location (Street and Number or Ritral Route Number, City or Town, Stete) or Attance efter death Director: by the 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1302 To the Hospital of within 24 hours e To the Funeral D House edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examinar: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and pleca, end due to the ceuse(s) end manner stated. 29a. Certifier 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number Q 27586 vice 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 8216 WIS CONSIN 2012 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

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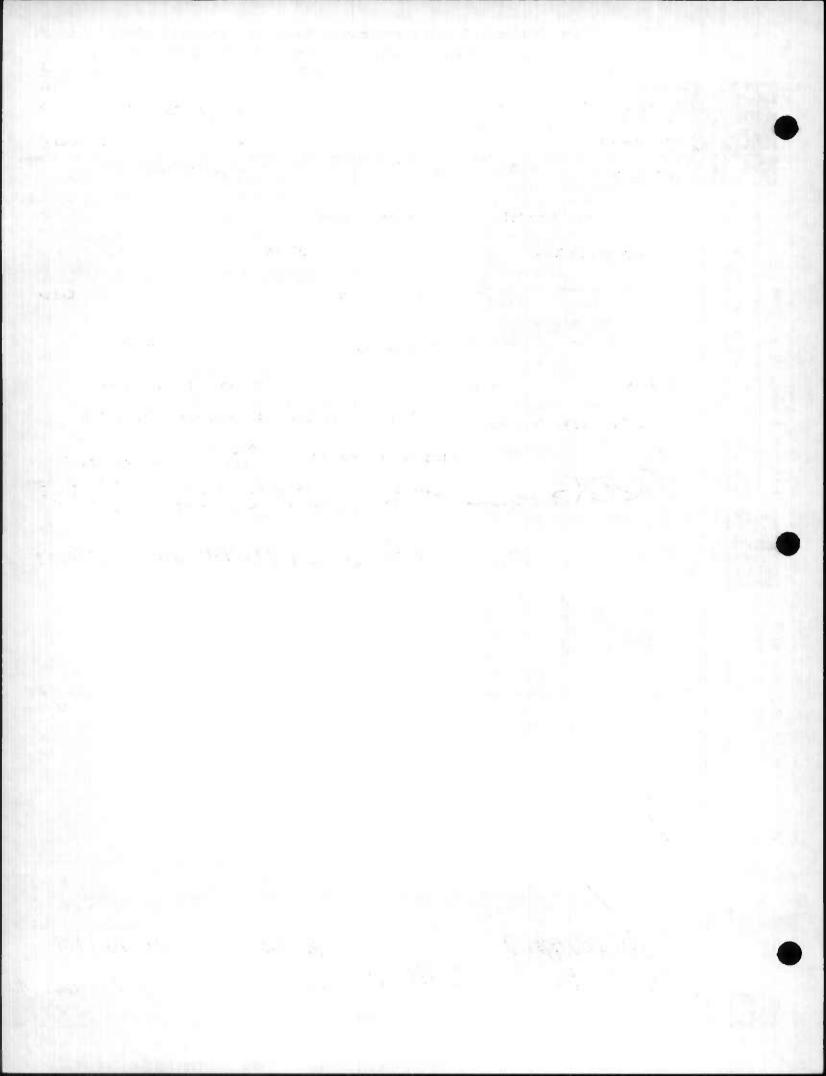
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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 3:30 pm June Norma Lowry 1997 October 25, /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 250 Riverdale Road Severna Park Anne Arundel 8. Date of Birth (Month, Dey, Ye June 16, 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Year) 1931 Days Months Hours 1 M 2 MF 213-28-8187 66 Yrs Director Maryland Usuei Residence of Decadent with the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Evanguer must be notified at MD 1 ☐ Yes 2X No Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 Riverdale Road 21146 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, permit. Pegas 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene. Important: if flem 27 is marked other than "natural", or iten any injury or other traumatic event, the Wedgal Exercises once. Black. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify þ 3 X Widowed 4 ☐ Divorced Completed 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Howard Schline Melissa Pratt Tawes 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 250 Riverdale Road, Severna Park, MD David P. Lowry, Jr., son 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Oct 29 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 1997 22. Name and Address of Facility Park Funeral Home Barranco & Sons, P.A. Severna 295 Gov. Ritchie Hwy., Severna Park, shock, or heart failure. List only one cause on each line. MD 21146 Physician /Medical immediate Cause (Final disease or condition resulting in death) coronary Vascular disease unknown Examiner Due to (or as a consequence of) Examiner physicien end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 98 950 ò signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24e. Was an eutopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed peen hes 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical exampler?

1 Yes 2 No Be 26. Piece of Death (Check oply one) Hospital: Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) funerai 27. Manuer of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? i or Attending F after death. Director: After After 14 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide filled in To the Hospital o within 24 hours af To the Funeral DI completely filled in 1 Pertifying Phyalclan: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner steted. edicai 29e. Certifier (Check only one) 29c. License number D 28640 29d. Date signed (Month, Dey, Yeer) 21114 JEFFREY BRIGGS, MD State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 7 3 5 7 9 7

3. Time of Death 8:30am			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** James Lewis Jr. 11 06 97 3:40 PM /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev. Year) Birthpiece (State or Foreign Country) **Funeral** Months Deys 1X0 M 2□ F 55 Yrs 051-50-9441 Director 04-04-42 Connecticut Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show Maryland Prince George's Bladensburg Director XXYes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 6020 Logan Way #B4 20710 238 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritel Status 14. Raca - American Indien, Bleck. White, etc. 1 and 2 should be filed within 72 hours effer of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No ff Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: by 3 Widowed 4 Divorcad Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the compared to the 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10th Painter Private 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be James Lewis Sr. Jean Jackson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 s
Department of Health an
Important: If Item 27 is a
any injury or other treu Jean Lewis/Mother 6020 Logan Way #B4, Bladensburg, Maryland 20710 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Chesapeake Crematory 11/8/97 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22. Neme end Address of Fecility J.B. Jenkins Funeral Home Downs 7474 Landover Road, Landover, Maryland 20785 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximeta Intervei Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of): physician ar Box 68760. Physician/Medical Due to (or es e consequence of): for use es ed by the e Pert il. Other significent conditions contributing to death but not P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown signed t Records, Completed by The law requires 24a. Wes en eutopsy 24b. Were autopsy findings eveileble prior to completion of cause of deeth? **Dege 2** 1 Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes cese referred exeminer? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No : Empationt 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA shis 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Neturei 5 Pending investigation after death. Director: Al 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Piece of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 2 4 Homicide 5 hours a 24 hours Funeral 29a, Certifier Medical Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examinar: On the base of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Sig 29c. License number 29d. Dete signed (Month, Dey, Year) 99 30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Lewis H. Dennis, M.D. 6201 Greenbelt Road, College Park, MD

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31. Dete filed (Month, Dey, Year)

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32 Registrer's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Date of Daeth 3. Tima of Death 1250 Month Year ANDREW MICHALITSIANOS OCTOBER 1997 4b. City, Town, or Location of Daath 4a. Facility Nama (If not Institution, giva street and number) 4c. County of Death Johns Hopkins HOSPITAL Baltimore 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Deys Hours XXM 2 F Yrs 055-40-1788 50 May 22 1947 Egypt Usual Residence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Anne Arundel Severna Park 10e. Straet end Number 10f. Zip Coda 10g. Citizan of What Country? 829 Dividing Road 21146 United States 12. Was Decedent Ever In U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: 1 Nevar Merried 2 X Married 1 ☐ Yas ZXNo Specify: White 3 ☐ Widowad 4 ☐ Divorced 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Goddard Space Flight Elamantary/Sacondary (0-12) Collaga (1-4or 5+) 12 Astro Physicist Center (NASA) 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Gerasimos Michalitsianos Marika Soultanakis 19a. Informant's Name/Reletionship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Kathryn Michalitsianos (Wife) 829 Dividing Road Severna Park, Maryland 21146 20b. Placa of Disposition (Nama of cematery, crametory or othar place) Nov . 3 1997 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland Demetrius Cemetery 22. Nama end Addrass of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Deeth Immadiata Causa (Final PVLMON427 EMGOUUS disaase or condition resulting in daath) TEN HOURS Dua to (or as a consequence of): SIX MONTHS (TUO BLASTOMA MULTERRAE Dua to (or es a consequance of): Dua to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Wara autopsy findings available prior to complation of cause of daath? 24e. Was en autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 No 28. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residance 6 Othar (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 2 Accidant 5 Panding

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar mast be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or fren any injury or other traumetic event

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Examiner Sequantially list conditions, if eny, laading to immadieta ceuse. Enter Undarlying Causa (Disaasa or injury that initiated events Physician/Medical thet initiated events resulting in death) Last

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28f. Location (Streat and Number or Rural Route Number, City or Town, Steta)

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Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated.

29b. Signatura and title of certifian Mr lemmer, MO

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29c. Licensa number

29d. Date signed (Month, Day, Year) OMOREN 29,

30. Nema and addrass of person who complated ceuse of deeth (item 23a) (Type, Print) M.D

M. LESNIAK

Tomus HOPKINS

28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify)

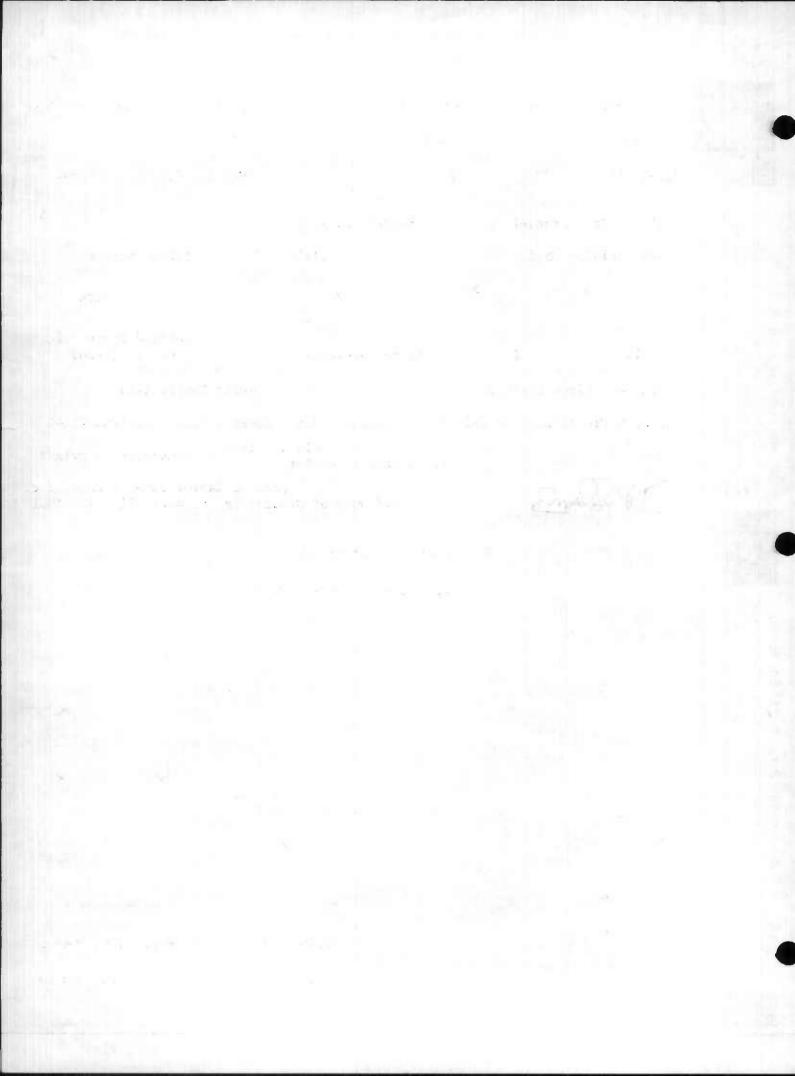
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State Registrar 31. Data filed (Month, Day, Year) NOV 03 1997

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32. Registrar's Signatura Adia Davidson



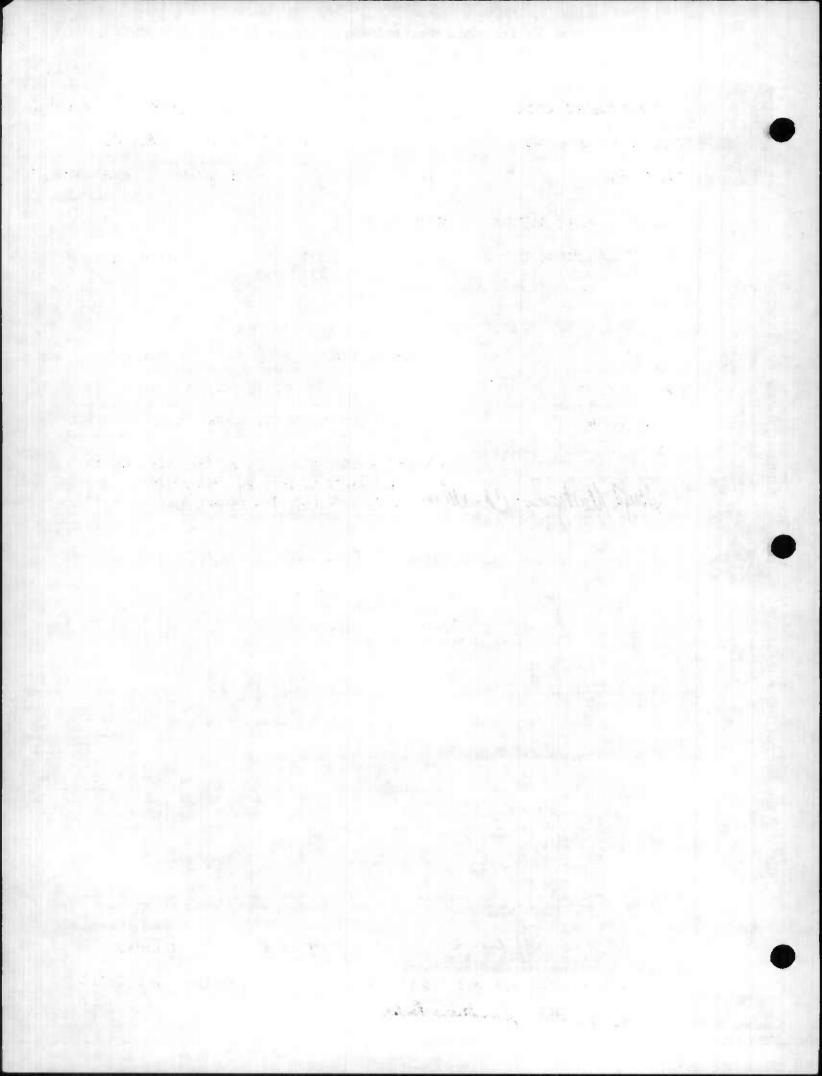
State of Maryland / Department of Health and Mental Hygiene

AMEND# 19b cms 11/5/97 AACO Health Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Time of Death Month **Physician** Frederick Moomau October 21, 1997 2:40 A.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Sinai Hospital Baltimore (City) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | April 23,] 5. Social Security Number 7. Aga (In yrs. lest birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F 233-44-5273 Yrs. 69 1928 Director West Virginia Usual Residence of Dacedent with the Maryland 10a. State 10b. County 10c. City. Town or Location or Items 23a or 28a-f show 10d. Inside City Limits treumstic event, the Medical Examiner must be notified at Maryland Montgomery County Director 1 Yas 2 No 01ney 10e. Street and Number 10f. Zlp Code 10g. Citizan of What Country? United States 17901 Prince Phillip Drive 20832 death Funerai of America 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours etter Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or the any Injury or other treumatic event, the Madical Expansion 1 Never Married 2 Married IX Yes 2 □ No If Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorcad White Year or Dates: Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decadant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry (Health Care) Elementary/Secondary (0-12) Collega (1-4or 5+) Physician 5+ Internal Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) William C. Moomau Sara Taylor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number of Fural Route Number, City or Town, State, Zip Code)
17901 Prince William Drive, Olney, Maryland Darlene Moomau/ Wife 17901 Prince m Drive, Olney, Maryland 20832 20c. Location - City or Town, Stata Petersburg, 20b. Place of Disposition (Name of cometery, cramatory or other place) 20a. Method of Disposition October Muriai 2 Cramation 3 Removal from State Maple Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 24. 1997 West Virginia 22. Nama and Address of Facility
Schaffer Funeral Home 21. Signature of Funeral Service Licensee M00690 ausan Petersburg, WV 23a. Pert1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bety Onset and Death Physician /Medical Immediate Causa (Final diseasa or condition resulting in death) Respiratory Arrest 30 Minutes **Examiner** Due to (or as a consequenca of): Examiner Cerebrovascular Accident 1 Months The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): buriel-trer Myocardial Infarction P.O. Box 68760. 1 Months Physiclan/Medicai 170 Due to (or as a consaquenca of): 5-6 Years Coronary Artery Disease 80 USB 0 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? page 2 should be detect 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Records, by 24b. Were autopsy findings aveileble prior to completion of causa of death? Completed 24a. Was an autopsy performed? certificate hes 2 No 1 ☐ Yes 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: Be director. 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Panding investigation 1 XNaturel s efter death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours edicai 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, data and piaca, and dua to the ceuse(s) and manner as stated. 29a. Certifian (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. To the To the To the 29b. Signatura and title of certifiar 29c. Licanse number 29d. Date signed (Month, Day, Year) A 5240 23 21 TL9284 October 21, 1997 30. Name and address of person who complated cause of daath (Itam 23a) (Type, Print) Sinai Hospital, Baltimore, Maryland 32. Registrar's Signature Pandall 31. Date filed (Month, Dey, Year) State NOV 0 4 1997 Registrar

State of Maryland / Department of Health and Mental Hygiene

					Certi	ificate of	Death		Reg. No.	1 3	5801
) Dhualaian	1. Decedent's Na	me (First, Middle, L	ast)					2. Date of De Month			3. Time of Death
Physician /Medical	BEVERLY	BEVERLY EVELYN MARSH							2,1997		05:10am
Examiner	4a Facility Name	(If not institution, g	ive street and number	er)			4b. City, Town, o	r Location of Deet	h 4c. Cour	nty of Death	
	HOLY CROSS HOSPITAL							SPRING		TGOME	
neral ector	5. Sociei Security 577-58-6	563	Sex 7 1 □ M 2]X F	Age (In yrs. last t		If Under 1 Yea Months Days			th ay, Year) 46		place (State or Foreign intry) IINGTON, D.
/ Funeral Director	Usual Residence	of Decedent		10c. City, To	wn or Loca	ition					10d. Inside City Limits
20			anonana								1X Yes 2 □ No
Director	MD 10e, Street end N	_	GEORGES	FURE	STVIL	10f. Zip Code			10g. Citizen o	of What Cou	into/?
Ö		LLOW RIDG	E CT				747				
era	11. Maritel Status		12. Wes Decede	nt Ever in U.S.	13. Wa			(Specify Yes or No	UNITEI	laca - Ameri	
by Funerai	1 Never Ma	rried 2 Married	Armed Force 1 ☐ Yes 24 If Yes, Give Year or Date	No		fes, specify Cu ☐ Yes 2X No		(Specify Yes or No erto Rican, etc.)	Spec		, etc. ACK
ted	/Sn	15. Decedent's E		16	a. Deceder	nt's Usuai Occi	pation e during most of w	vorkina	16b. Kind of	Business/Ir	ndustry
nple	Elementary/Se	condary (0-12)	College (1-4c	or 5+)	life. DC	NOT use retir	ed)				
event, the Medical I	12		0		SOCIA	L WORK					
Be		e (First, Middle, Las	st)							eme)	
2	WILLIE			1			1				
		Neme/Relationship	(Type, Print)								
	TERRY N						KIDGE CT.				
	20a. Method of D	•	☐Removel from Sta	como	tery, crema	tion (Name of tory or other p	ace)	Date	20c. Locatio	n - City or T	own, State
	4 Donation	5 Other (Spec	ity)	LINCO	LN ME	EMORIAL	PK	11/15/9	7 SUITI	AND,	MD
	21. Signature of I	uneral Service Lic		11	AL F	Name and Add EXANDER	S. POPE	FUNERAL	HOMES		
5	Sough	Mactro		cathon	553	38 MARL	BORO PIK	E FORESTY	VILLE M	D 207	47
	23a, Part I, Eglad	disease, or co	mplications that caus	sed the death. Do	o not enter	the mode of dy	ring, such as cardi	iac or respiratory e	rrest,	1	Approximate
an			, mm 52255 511 525	, 11.0.							Onset end Death
cal	Immediate Cause disease or condit	(Final		LIVE	0	ENIL	unit				2 13013
er	resulting in deeth		е	Due to (or es						1	
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Examiner	Sequentially list of	conditions,	D	Due to (or as							
EX	Sequentially list of any, leeding to cause. Enter Unicause (Disease that initiated ever	immediate derlying		BARA	55	CM	con				
edicai	thet initieted ever resulting in death	ots) Last	C	Due to (or as a	-		-				
in/Medical Examir											
Physician/M			d								
/sic	Parl II. Other sign	ificant conditions	contributing to death	but not resulting	In the und	lerlying cause (iven in Part I.				
								10	Yes 2 N	0 3 Pr	obably 4 Unknown
d by Physic										0.00	Mana auto E- V
Completed										a	vailable prior to
pie										0	f deeth?
Con								10	Yes 2 No	1	☐ Yes 2☐ No
Be	25. Was case ref	erred to medicat						eath (Check only	one)		
10	1 Yes 2	No	Hospitel: 1 Inpe	atient 2 ER/	Outpetient	3LI DOA	4 LI Nursing	Home 5□ Resi	idence 6 🗆	Other (Spec	ity)
	27. Manner of De 1 Dinatural	ath 5 ☐ Pending	28a. Date of II (Month, ii	njury 28b Day Year)	. Time of injury			28d. Describe	how injury oc	curred	
Certification:	2 Accident	investigati	on								
THE STATE OF THE S	3 ☐ Suicide 4 ☐ Homlcide	6 Could not determine	d 286. Place of	Injury - At home, etc. (Specify)	farm, stree	et, factory, offic	9			m <i>ber or R</i> u	ral Route Number,
Cer											
edicai	29a. Certifier (Check only one)			of examinetion e							
Me	29b. Signeture er	d title of certifier	and monitor			29c. Lice	nse number		29d. Date sig	ned (Month	, Day, Year)
	L	111	1. lun	· m			WORKER 18. Mother's Name (First, Middle, Maiden Surneme) EVELYN SKINNER dress (Street and Number or Aural Route Number, City or Town, State, Zip Code) LLOW RIDGE CT. FORESTVILLE, MD 20747 (Name of vor other place) Date 20c. Location - City or Town, State ORIAL PK 11/15/97 SUITLAND, MD 11/15/97 SUITLAND, MD 12/15/97 SUITLAND, MD 13/15/97 SUITLAND, MD 14/15/97 SUITLAND, MD 15/15/97 SUITLAND, MD 16/15/97 SU				
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State	31. Date filed (Mo	1 1 2 100	32 Regi	Suars Signature	mobal!						
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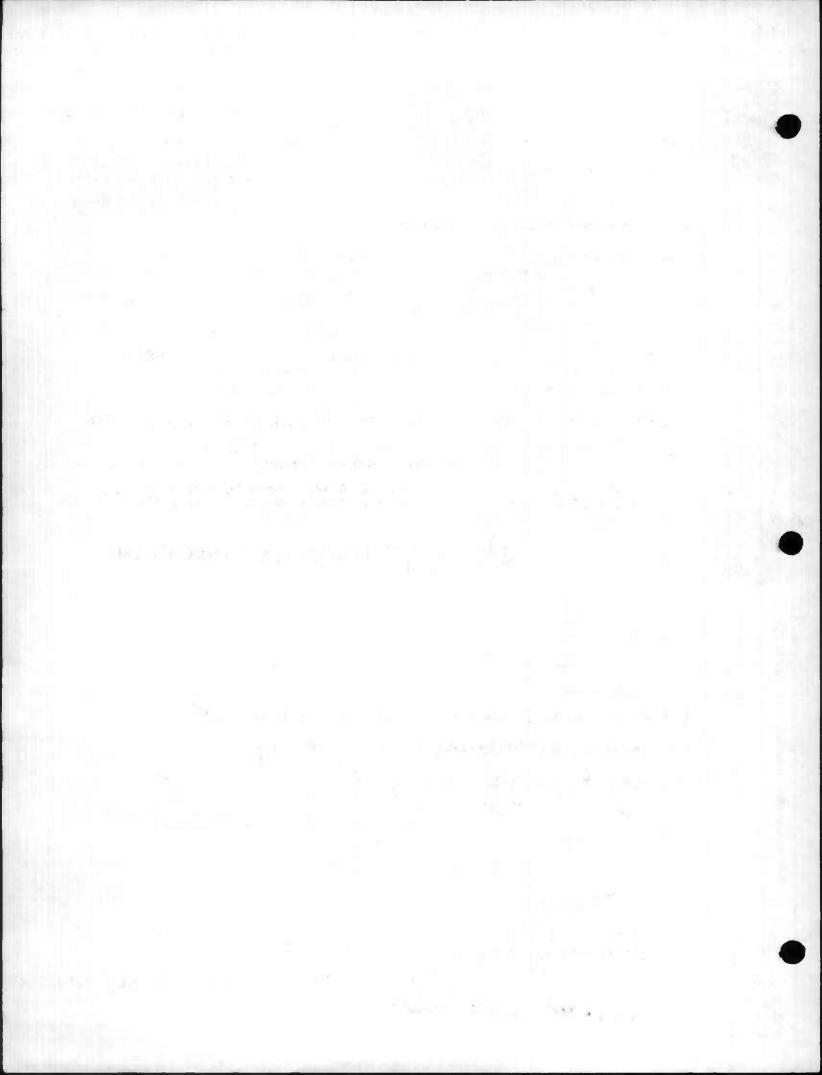
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First Middle Last) 2. Deta of Deeth 3. Time of Death **Physician** Month Yaer John Vincent 13, 1997 Motta, Jr. November 6:10 am /Medical 4e. Fecility Nema (If not Institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Prince George's Medical Center Cheverly Prince George's 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Undar 24 Hrs 8. Dete of Birth (Month, Dey, Year) Birthplece (Steta or Foraign Country) 7. Aga (In yrs. lest birthday) **Funeral** Months Days Hours 71 Yrs Director 032-14-2874 Aug. 10, 1926 Winthrop, MA. Usual Residence of Decedent e filed within 72 hours efter deeth with the Meryland al Hygiene. other than "naturel", or flems 23s or 28s-f ehow 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits traumetic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Prince George's Landover Hills 10f. Zip Code 10g. Citizen of What Country? 3809 71st Avenue 20784 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1 ☐ Never Married 2 X Married 1 XYes 2 No If Yes, Give Year or Detest 944-1946 Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Loan Officer Banking permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be John Vincent Motta Georgianna Motta 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Frances M. Motta / Wife 3809 71st Avenue, Landover, Maryland 20784 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete D Buriai 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Spacify) Maryland Veterans Cemetery Cheltenham, Maryland 21. Signeture of Funeral Service Licenses 22. Nema end Addrass of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 erson 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or hear feilure. List only ona cause on each line. Approximete Intervel Between Onsat and Death **Physician** /Medical Immediate Ceuse (Fine) TAGE CONGESTIVE HEART PAILURE diseesa or condition resulting in daath) Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate ceuse. Entar Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) physician Box 68760 Physician/Medicai Due to (or as a consequence of): been signed by the atter should be deteched for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? o 1 Nes 2 No 3 Probably 4 Unknown 0 Obstructive Division of Vital Records, Completed by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? EMPITYSEMA H 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: '24 hours after death.
 Funeral Director: After this certifica Be 25. Wes cese referred to medical axeminer? 26. Pieca of Deeth (Check only ona) Hospite Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the best of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. 29a. Certifier To the Hosp vithin 24 hou To the Fune completely fi Medical (Check ont) 29d. Date signed (Month, Dey, Year) 24/0 30. Name end eddress of person who completed ceuse of deeth (item 23e) (Type, Print) reyes 6501 LANDOVER FD CAEVERLY UTD 20785 164MOR or. D

State Registrar 31. Dete filed (Month, Dey, Year) NOV 1 4.1997 39 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended # 16b & State of Maryland / Department of Health and Mental Hygiene, Certificate of Death PG,GC, 11/18/97 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** McCoy Sr. Norman Samue 1 November 9, 1997 2:55 A.M. /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Livingston Health Care Center Fort Washington Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, 8/2/02 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. Director 578-56-0553 92 Jacksonville, Fla Usual Rasidence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours effer deeth with the Marylan of Health end Mental Hygiene. Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantiner must be notified at ∏yes 2□No Directo Md PG Hyattsville 10e. Sireet end Number 10f. Zip Code 10g, Citizen of Whet Country? 1008 Ray Road 20783 USA Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. 1 ☐ Yes 2♥ No If Yas, Giva Yaar or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specity: Specify: Black þ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Public Schools Private Indust Elementary/Secondary (0-12) College (1-4or 5+) 12 Years 2 Years Class I Engineer 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be Maryetta Mayetta Stafford Wyatt McCoy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Coda) Mattie Taylor(Foster Daughter) Rte 238, Box 263, Chaptico, Md., 20621

20a. Melhod of Disposition

20b. Place of Disposition (Name of commeter), cramatory or other place)

Lincoln Memorial Cemetery 11/13/97

Suitland, Md. 20a. Method of Disposition
TD Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, Stete permit. Peges 1
Department of H
Important: If iter
any Injury or ott 21. Signature of Funerel Service Licensee 22. Name and Address of Facility
John T. Rhines and Company lucan 3030 12th Street, NE . Enter the disease, or complications that caused the deeth. Do not where the property difference according to the contract of Approximate Interval Batween Onset and Death **Physician** Immediate Causa (Final diseasa or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner ettending physician end for use es the buriel-transit Sequentially iisi conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760 certificate be Physician/Medical thet initiated events resulting in death) Last Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ anent 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy hes page certificate 1 Tes No No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Plees of Deeth (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: XX Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) 1 Yes 2X No 2 After this 28c. Injury ai Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division Attending 5 Pending investigation 1X Neturei injury deeth. 1 Yes 2 No or Attendi effer deeth Director: A 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida to the Hospital of the funeral Di 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier (Check only one) end manner steted. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number

State Registrar

31. Dete filed (Month, Day, Year)

NOV 13 1997

A.

Robert

30. Nama and address of person who completed causa ordinath (lan 23a) (Type, Print)

McConnaughy, M.D. 11418

Day, Year)

13 1997

Abi division Reviel

(301) 292-1800

11418 Livingston Road, Fort Washington, MD 20744

State of Maryland / Department of Health and Mental Hygiene

Physicia	an l	1. Decedent's Name (First, Middle, Las	it)	3 -1					2. Data of Daa Month	th Day	Yaar 3. Tim	e of Death
/Medic		Marie Eleanor	Mortime		Gonega	1			Novembe			9 am
Examin	er	4a. Facility Name (If not institution, give)			4b. (ocation of Death	4c. County	of Death	
		11805 Wayneridge				William A	4	Fulton	T-2-2	Howa		
uneral irector		21/-44-0/50	ex 7. A	ga (In yrs. 86	last birthday) Yrs.	If Under 1 Months E		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 1,	, Year) 1910	9. Birthplace (Sta Country) Washingto	te or Fo
MOI III		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	cation					10d. Insid	e City Lin
r 28a-f show Inputfied at	to	Maryland Prince G	eorge's	La	aurel						1短	Yas 2
or 28s	irec	10e. Street and Number				10f. Zip Co	ode			10g. Citizen of V	Vhat Country?	-
23a or	aj D	8013 Aladdin Driv	e			1	20723	3		U.S.A.		
or Items	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedant Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? [No		Vas Deceden Yes, specify			pecify Yas or No- o Ricen, etc.)	14. Race Blace Specify	e - Amadcan Indian kk, White, etc. : White	1,
than "natural", re Medical Exe	Completed by	15. Decedant's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucetion de completed) College (1-4or	5+)	16a. Deced (Give I life. L	ent's Usual C kind of work of OO NOT use	Occupatio done duri retired)	upation e during most of working ed)			usiness/Industry	Industry
1	200		2		Secr	etary				U.S. Governmer		
marked other th	Be	17. Father's Name (First, Middle, Last)					18			e, Maiden Sumame)		
ls marked or raumatic eve	P	Benjamin C. Morti							ine Vict			
Is II		19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailin	19b. Mailing Address (Street		d Number or Ru	ral Route Numbe	te Number, City or Town, State, Zip Co		ode)
em 27 I		Victor A. McGoneg	al - Son_					rive, L	aurel, M			
or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		Place of Dispos emetery, crem	sition (Name natory or othe	or piace)	i	Date	20c. Location -	City or Town, Stat	а
ury o		4 Donation 5 Other (Specify		For	t Line	oln Ce	emete	ery	11/14/97	Brent	wood, Man	yla
Department or regular important: if them 27 is any injury or other tra		22. Name and Address of Facility Francis Gasch's Sons Funeral Home, F 4739 Baltimore Avenue, Hyattsville,									, P.A.	0781
		23a. Part1. Enter tha diseasa, or com shock, or heert feilure. List only			h. Do not ente	ar tha moda o	of dying,	such as cerdiad			Approx	Imate Betwee
ysician ledical aminer		Immediate Cause (Final disaasa or condition resulting in deeth)	Eas S	tage2	Alyhe	LU31	() por	entin			gr	1
	Jer		molunt	Due to (c	or es e conseq	uence of):					wk	. (
and al-transit	xami	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):									
physician and s the bunal-transit	edical Examiner	Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Olsease or Injury that initieted events resulting in death) Last	CDue to (or as a consequenca of):									
	clan/M		d									
atte I for		Part II Other plantileast conditions o	antributing to doub	but not roo	ulting in the us	adodvina onu	eo airea	In Part I	23h Did t	obacco usa co	ntribute to the car	use of d
ned by the attending detached for use a	Phys	Hyperters in	aditional contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use c 1 Yes 2 No 24a. Was an autopsy performed?				m Patti.				¥ Uni	
been sign	Completed by	10					24b. Were auto available p completion of death?	osy findi rior to of caus				
page 2	E		1□ Yes						res 2 No	1 ☐ Yes	2□ No	
certificate rector, pag	Bec	25. Was cese referred to medical					2	26. Place of De	ath (Check only o	ne)		
fter this ineral di	ပို	examiner? 1 Yas 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	Hospital: 1 Inpat	jury	ER/Outpatien 28b. Time of Injury		: Injury a Work?		dome 5 Rasid		ear (Specify) Surred	ng 14
	edicai Certification:	3 Suicide 6 Could not be determined	be Co. Diseased being At home form street factors office. 28f Location (Street and Num						ber or Rural Routa	Number		
within 24 hours erter of the Euneral Direct completely filled in by	dicai (29e. Certifier (Check only one)	ysician: To the bes niner: On the basis and manner s	of examina	wledge, death tion and/or inv	occurred at restigetion, in	the time, my opin	date and plece ilon, death occu	e, end due to the urred at the time,	cause(s) and m dete end piece,	anner as stated. end due to the ceu	ıse(s)
To the	Me	29b. Signature and title of certifier				29c. l	Licansa n	number		29d. Date signe	d (Month, Day, Ye	ar)
7		Kompia	Δ)-7	4868	1	Vovenber	5 12/199	17
		30. Neme end eddress of person who	completed ceuse of	deeth (Iter	n 23e) (Type,	Print)		0.7	01 1			

A Section of the sect

State of Maryland / Department of Health and Mental Hygiene 9 7

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Dey , 1997 **Physician** Reginald Martin Sr. November 3:10PM /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Carriage Hill Nursing Center Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | April 21, 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1√M 2□ F 577-36-7201 89 Yrs. 1908 Wash., D.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner, must be notified at 1 ☐ Yes 2 ☐ No Director District of Columbia Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1830 Varnum St., N.W. 20011 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ANo if Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: **Black** Specify: by 3 Widowed 4 Divorced Completed 18a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Businessman Gasoline other 17. Father's Name (First, Middla, Last) permit. Pages 1 and 2 should be file.
Copartment of Health and Mental Hy
Important If from 27 is marked oth
any injury or other traumatic event 18. Mother's Name (First, Middla, Maiden Surname) Be George W. Martin Emma Moore 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Reginald F. Martin, Jr./Son 1314 Floral St., N.W. Wash., D.C. 20012 20a. Method of Disposition 20b. Place of Disposition (Nema of cematary, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 11/15/97 Landover, MD 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Puneral Service Licensee 22. Name end Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 23a. Part / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, show, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final PNEUMONIA 1d. disease or condition resulting in death) Examiner Examiner certificeta be executed physician and s the burial-transit Sequentially list conditions, if any, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): P.O. 1 Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 5 Dehydration 1 Yes 2 No 3 Probably 4 Unknown signed l Records, þ 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Be Completed peeu completion of ceuse of death? page 2 s 1□ Yes 2 No 1 Yes 2 No cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartification at the funeral director, it 25. Was cese referred to medical exeminer? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 - Homicide edical 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

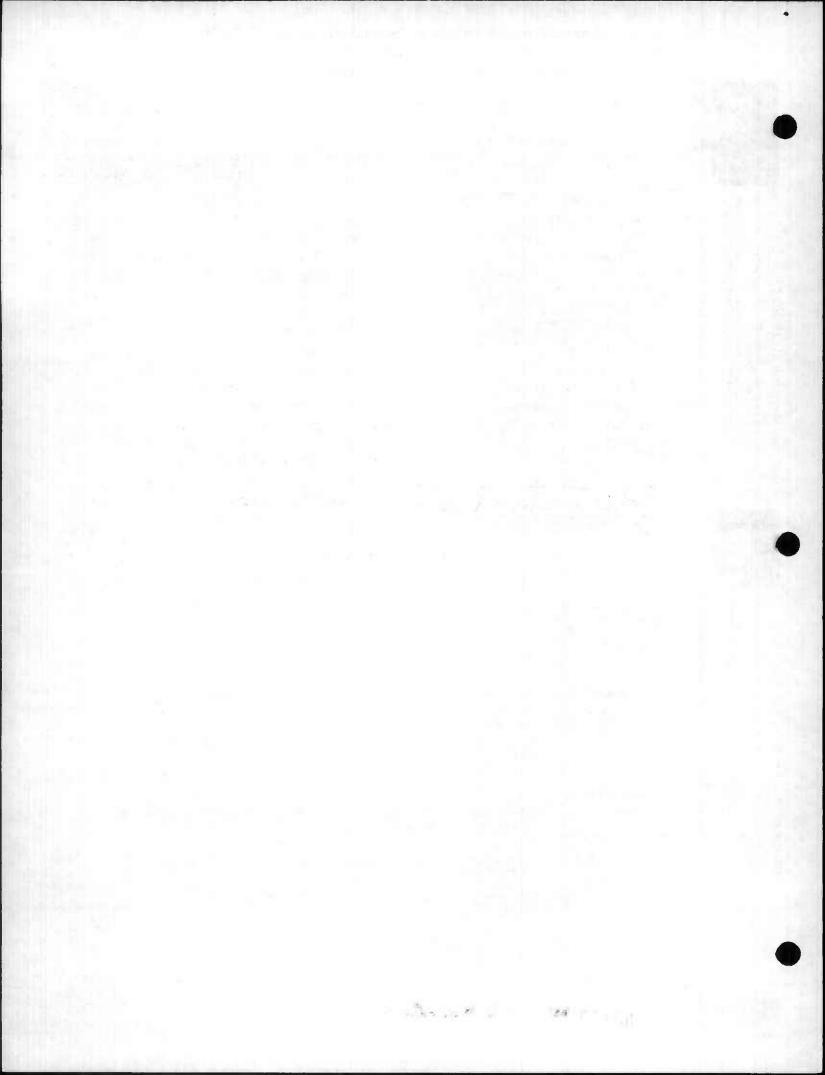
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ly Chaleleur mo D42518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUL CITABLANI, MB, 11119 Rockwiller Piker #316, Ruckeviller, MB, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

NOV 13 1997

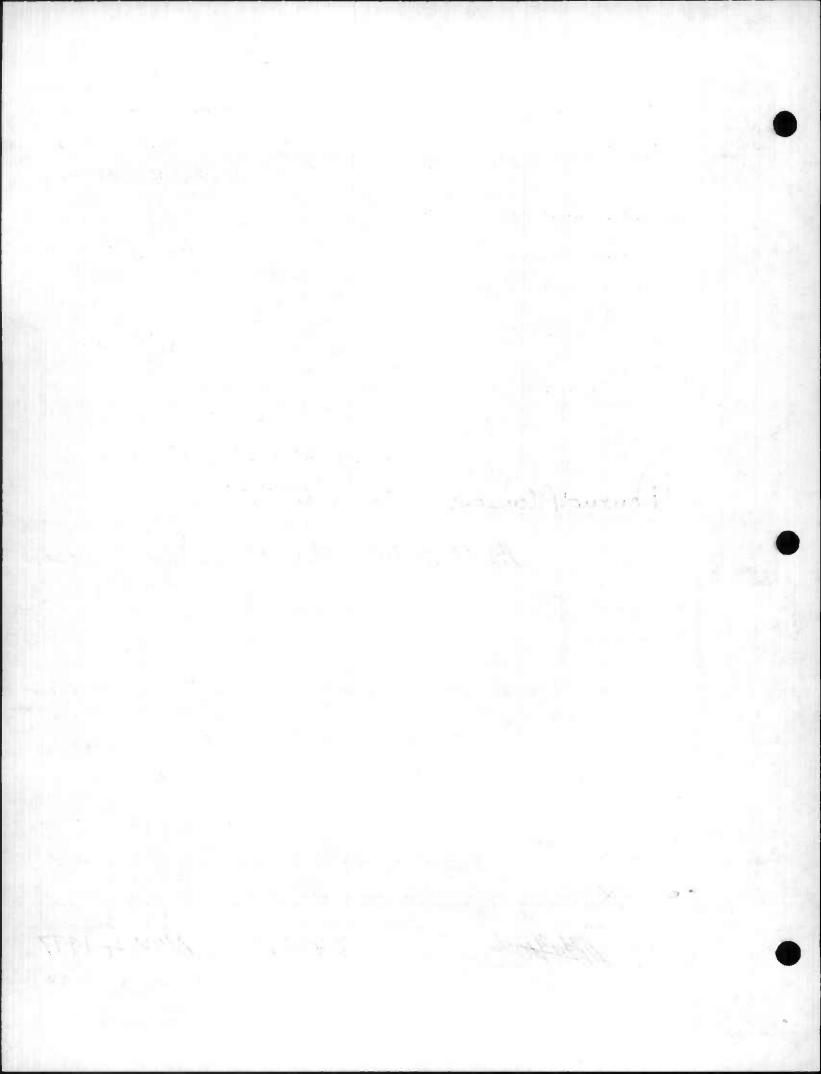


State of Maryland / Department of Health and Mental Hygiene /

Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Shirley Marie Nelson 3:58 PM November 1, 1997 /Medicai 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** 5608 Butterfield Drive Clinton Prince George's 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** 1□M 2₩F Months Days Yrs. 46 Director 225-82-1383 Oct. 8, 1951 Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Instde City Limits 28a-f show the Medical Examiner must be notified at Maryland Prince George's Clinton 1 ☐ Yes 2X No Director 10g. Citizen of What Country? United States 10e. Street end Number 10f. Zip Code or items 23a or 20735 5608 Butterfield Drive of America 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2K Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced "natural", Black Completed 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Blue Cross/ Pages 1 and 2 should be filed within nent of Health end Mantel Hygiene. Int: If Item 27 Is marked other than Elementary/Secondary (0-12) Collage (1-4or 5+) Blue Shield Computer Analyst Insurance 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Robert G. Thompson Dorothy C. Redman 19a. informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2. Depertment of Health el Important: If Itam 27 Is any Injury or other trat Husband 5608 Butterfield Drive, Clinton, Maryland 20735 Zacharias Nelson/ 20b. Place of Disposition (Name of comatery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cramation 3 ☐ Removal from State November Salem Baptist Church Cemetery 8, 1997 4 ☐ Donation 5 ☐ Other (Specify) Mount Holly, Virginia e of Funerel Service Licensee #M00690 22. Neme and Address of Facility Barry O. Waddy Funeral Home 6784 Mary Ball Highway, Lancaster, VA 22503 23a. Part1. Enter tha disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdlec or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** reast Carrer /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician end s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in daath) Last Due to (or as e consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Records, þ cate has been sig. Completed 24a. Was an eutopsy performed? 24b. Were autopsy findings aveileble prior to complation of cousa of death? 1 Yes 2No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA MNO Other: 4□ Nursing Home Residence 8 □Other (Specify) 2 1 Yas /s after da... 27. Maprier of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how Injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Sulcide 8 Could not be datarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral DI completally filled in Certifying Physician: To the best of my knowledga, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. cal 29a. Certifier (Check only 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number 30. Name and address of parson who completed causa of death (Item 23a) (Type, Print) HATTICKS Dr., Ste. 105 WAlder MD 20603 MEELU, mo #2 54 Ashraf 32 Begistraca Signature Handall 31. Date filed (Month, Dey, Year) State NOV 05 1997

Registrar

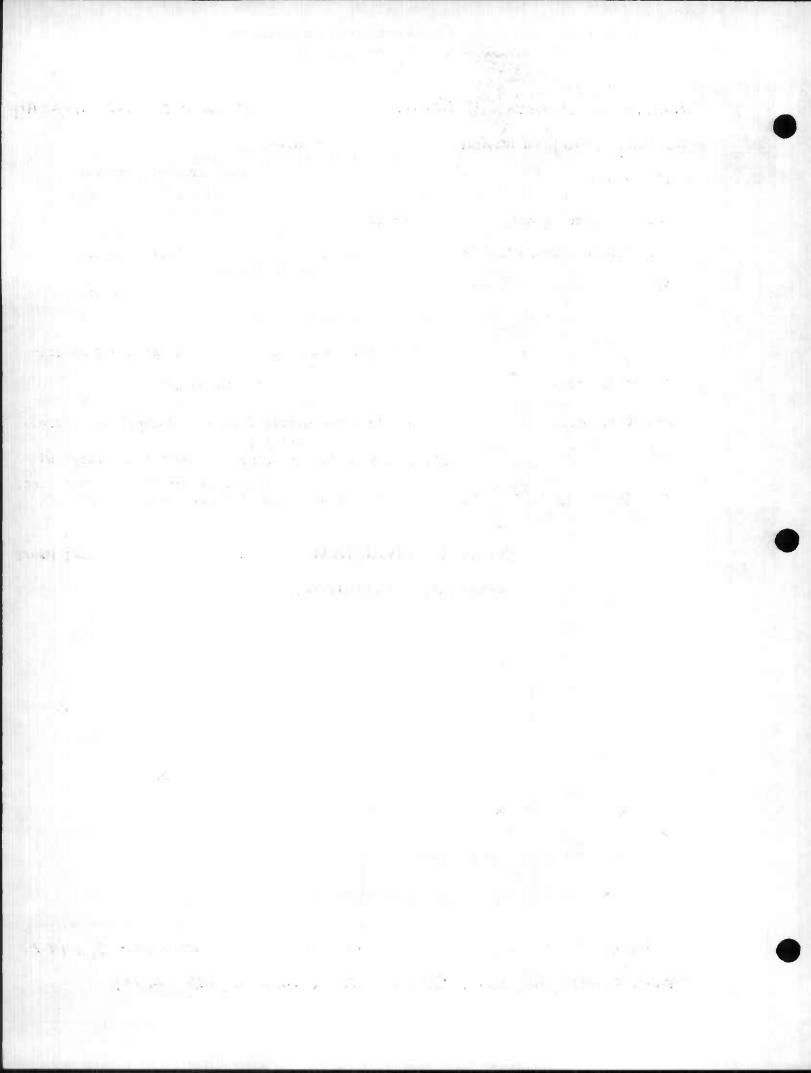


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Month North Kenneth 1997 James November 11:28 AM 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Hospital Baltimore
If Undar 1 Year If Under 24 Hrs. Sex 1 M 2 F 8. Data of Birth (Month, Dey, Year) Sept 29 19 Age (In yrs. last birthday) Birthplaca (Steta or Foreign Country) **Funeral** Months Days Hours 35 Yrs. 1962 Director Maryland 212-82-0408 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Odenton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nest of Health and Mental Hygiene.

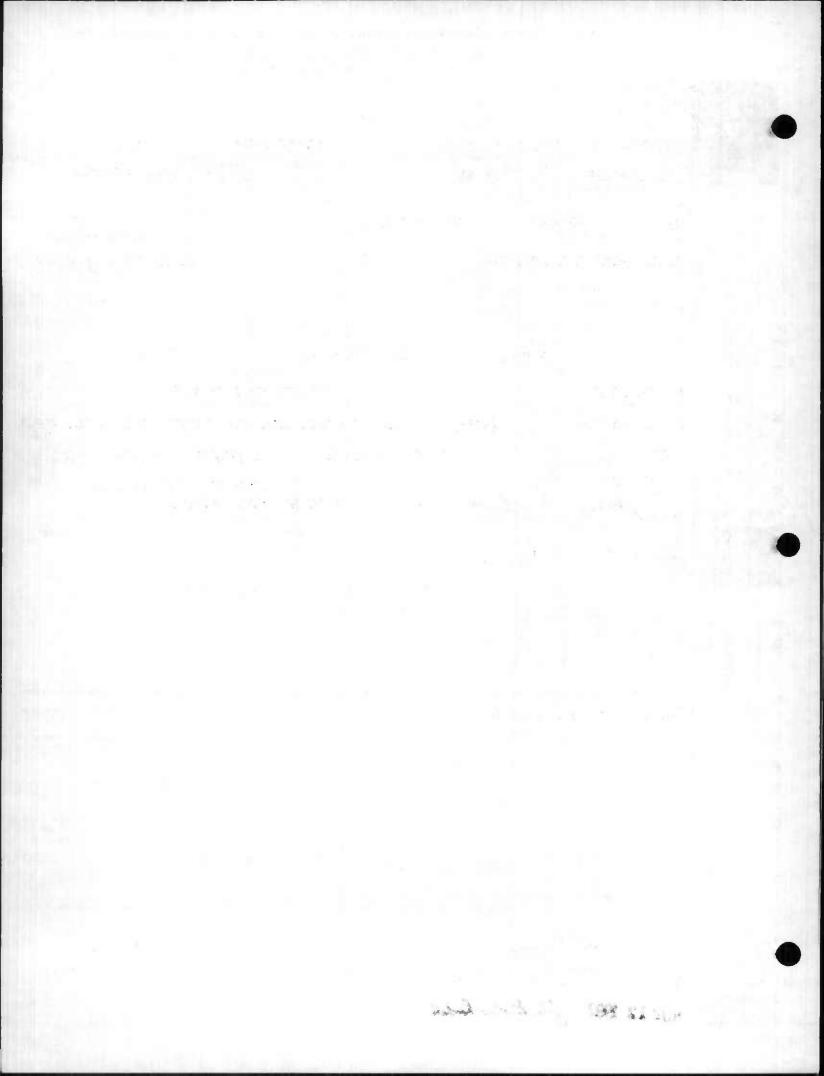
nt: if item 27 is marked other than "natural", or items 23a or viny or other traumatte event, its Magical Example or marke 695 Winding Stream Way #201 21113 United States Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 22 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1. Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h, Kind of Business/Industry the M Elemantary/Secondary (0-12) College (1-4or 5+) Automobile Mechanic Automobile Technician 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Robert R. North Martha Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, State, Zip Code) Robert R. North 15 Silverwood Circle Unit # 11 Annapolis, Md 21403 20b. Place of Disposition (Nema of cemetery, cramatory or other place) 11/8/97 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: if it any Injury or once. 1 verial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillcrest Memorial Cemetery Annapolis, Maryland 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Servica Licensee Jugor 147 Duke of Gloucester St. Annapolis, MD21401 23a. Part1. Enter the disaase, or coor lications that raused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer feilure. List on y one cause of each line. **Physician** /Medical Immediate Cause (Final herniation 24 hours disease or condition resulting in death) **Examiner** Examiner law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enler Undarfying Cause (Disease or Injury that initiated events resulting In dealh) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequanca of) 88 950 signed by the a d be detached f Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24a. Was en eutopsy periormed? 24b. Were autopsy findings aveilable prior to completion of cause of death? page 2 1 Yes 2 No 1 Yas 2 No certificata Hospital or Attending Physician: 25. Was case referred to medice! Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yas 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar 1 Natural 5 Pending after death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not ba determined 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Streat end Number or Rurel Routa Number, City or Town, Stete) 4 Homicide 24 hours a 29a. Certifier 1to Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune complataly fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner steted. 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) P100 36 November 5, 1997 ed ceuse of death (Item 23a) (Type, Print) Bahara E. Lazio, 22 S. Greene St., Balkmore, MD 31. Date filed (Month, Dey, Year) 32. Registrar'a Signature Mia Davidson State Registrar 06 199

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 9 30 Day Q Month **Physician** NOVEMBER 7,1997 ELIZA NASH /Medical 4e. Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BACTIMO REMD 3330 Wilkens Aur ATON MANCE 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2PE 063 2075 92 Director 1-29-15 N.C. Usual Rasidance of Dacedant 10e. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 XYas 2 No Director Prince Georg's HYATSVILLE Md -10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Funeral 5329 CRITIDEN STREET 20781 USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, etc. 11. Marital Status 1X Nevar Merriad 2 ☐ Married 21215-0020 1 Yas 2 No Specify: by 3 Widowed 4 Divorced Year or Datas: Black Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Haalth and Mental Hygiena. Important: If Itam 27 Is marked other than ' any Injury or other traumatic event, me Ma Collega (1-4or 5+) Elamantary/Secondary (0-12) Department Social Ser. Health Care 12 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Pagas 1 and 2 should be nent of Health and Mental MARGRET H. ODUM 0 JERRY NASH 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) NIECE 5329 CRITEDEN STREET HYATSVILLE MD. 20781 DORIS NASH, 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stata HASTINGS ON 4 ☐ Donation 5 ☐ Othar (Specify) HOPE CEMETERY 11 - 14 - 97HUDSON N.Y. 21. Signetura of Juneau Service Licensee 22. Nama and Addrass of Facility B. F. TAYLOR FUNERSAL SERVICES 1722 NORTH CAPITOL STREET N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. NORTH CAPITOL STREET N.W. Approximata Interval Between Onset and Death Physician Cerelo vascular Acadent /Medical Immediata Causa (Final disease or condition rasulting in daeth) Examiner Examiner Sequantially list conditions, if any, laading to Immadiata causa. Enter Undarlying Causa (Disaasa or Injury that Initiated avants rasulting In daath) Lest burial-tran Dua to (or as a consequence of): ding physician Physician/Medical Dua to (or es a consequance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Wunknown 1 ☐ Yes 2 ☐ No þ 24b. Wara autopsy findings eveileble prior to complation of causa of daath? Be Completed 24a. Was an autopsy erebororcular feedent Tha 1 Yas 20 No 1 ☐ Yas 2 ☐ No Attending Physician: 25. Was casa referred to madical axaminar? 26. Placa of Daath (Check only one) Othar: 4 Aursing Home 5 Residence 6 Othar (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Certification: To Aftar this 28c. Injury at Work? 27. Mannar of Deeth 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural death. 1 ☐ Yas 2 ☐ No 2 Accident After death 6 Could not be datamined 3 Sulcida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) in by 4 Homicida To the Hospital within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifier Medical (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Yeer) 11-10-97 Attending Doctor 30. Nama end addrass of person who complated causa of death (Itam 23a) (Type, Print)

State Registrar 31. Deta filad (Month, Day, Year) NOV 12 1997

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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** NOVEMBER NIXON 12:33 **EMMA** LOUISE /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY Wunder 24 Hrs. 8. Date of Birth (Month. Pay. Year)
JUNE 17, 1934
NORTH CAROLINA If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** 1□ M 2□F Yrs 246-50-2919 63 Director Usuei Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Magical Examiner mast be notified at 10d. Inside City Limits 1 ¥Yas 2 □ No Director MARYLAND PRINCE GEORGE'S SUITLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3701 DIANNA ROAD 20746 USA death Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Give Yeer or Dates: 14. Rece - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel, or Herr any Injury or other traumatic event, the Medical Exercises once." 1 Never Married 2 N Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No P Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 2 years DEPT. OF EDUCATION PROGRAM GRANT ANALYST 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) EMMA ROSS ROY L. HILL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) RICHARD NIXON / HUSBAND 3701 DIANNA ROAD SUITLAND, MD 20746 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 □ Buriel 2 □ Cremetion 3 □ Removal from State ARLINGTON, VIRGINIA 11 - 12ARLINGTON NATIONAL CEM 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility MARSHALL S FUNERAL HOME 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Ceusa (Finat diseesa or condition resulting in daath) Examiner physician and the burial-frensit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Physician/Medical use signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 32 No 3 Probably 4 Unknown by 24e. Wes en autopsy performed? 24b. Were eutopsy findings evallable prior to completion of cause of daeth? Completed peen hes certificate Division of Vital 25. Was case referred to madicai 26. Plece of Death (Check only one) 1 Yes 2√ No 27. Menner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA this funeral Proposed or Attending Pl 24 hours after death. Funeral Director: After the 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Naturel 5 Panding Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piaca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide ipletely filled in To the Hospital within 24 hours a 15 Certifying Physician: To tha best of my knowledge, deeth occurred et tha tima, date end pieca, end due to the ceuse(s) end mennar es steted.

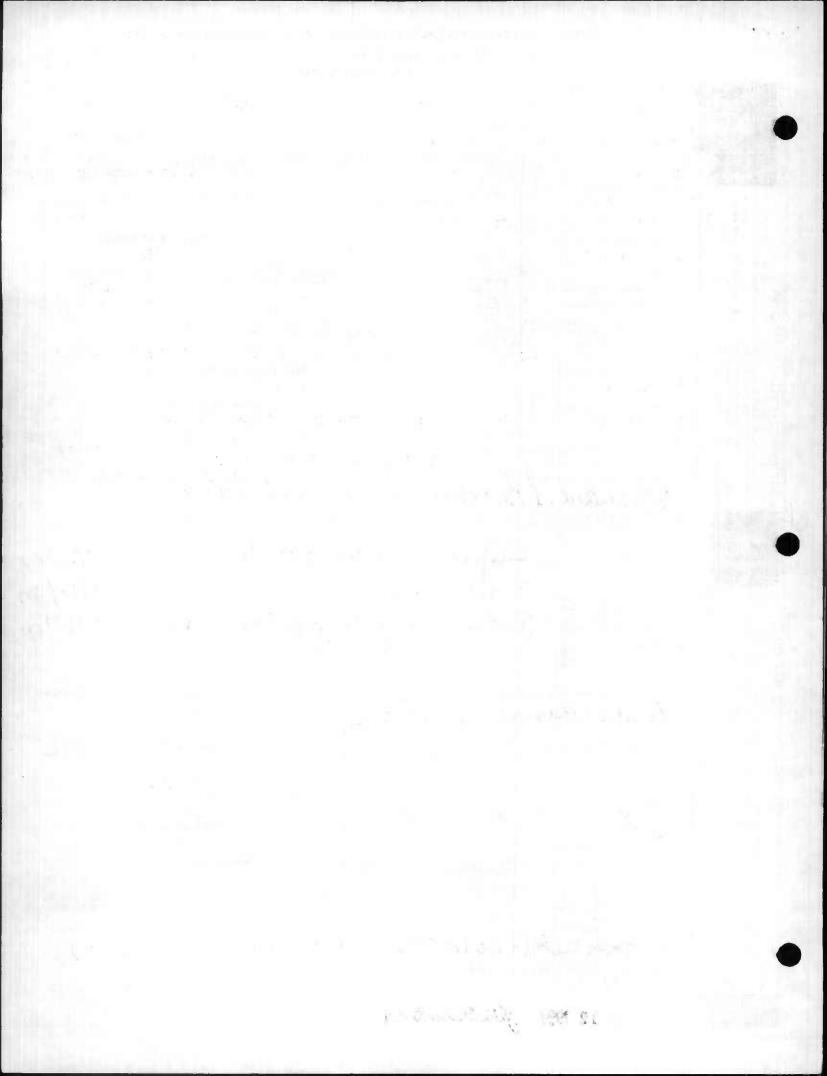
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and eddrass of person who complated causa of daeth (Itam 23a) (Type, Print) Kasheld. 31. Deta filed (Month, Day, Year) 32. Ragistrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 7

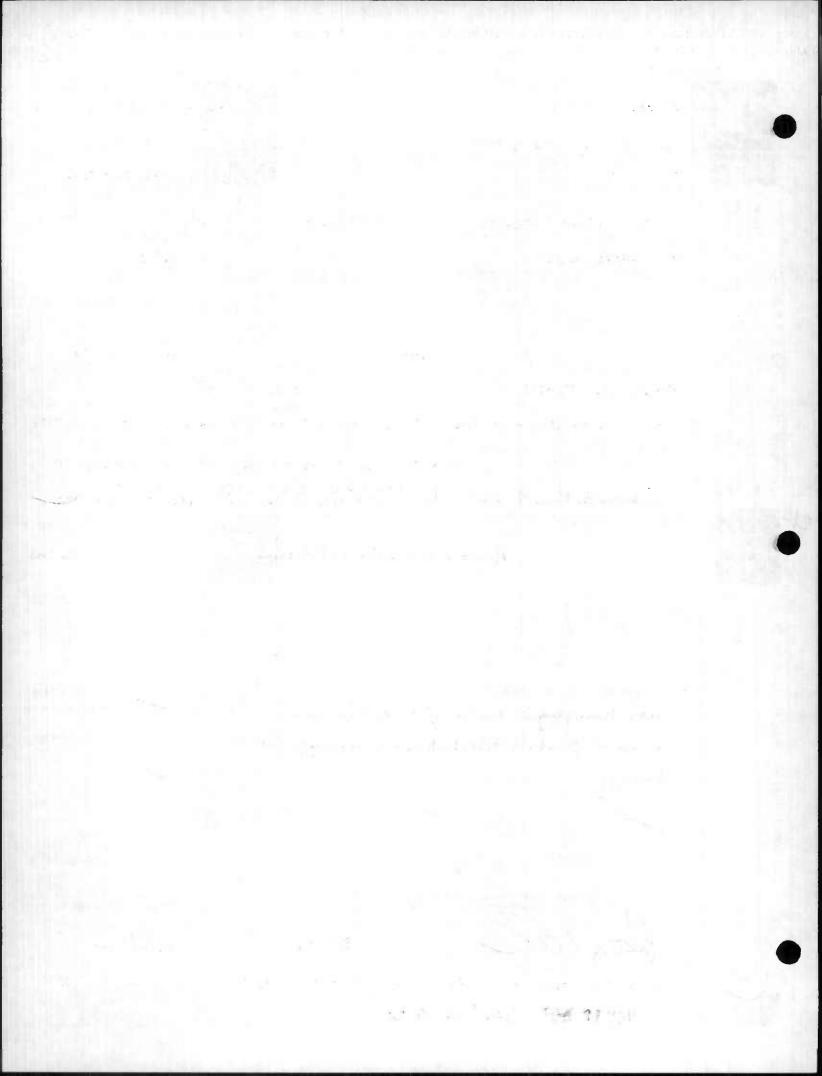
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					Certinic	ale of	Death	1	R	eg. No.			
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Physici /Medi		Charles	Lester O	wen					Month	Day 29 199	Year 7	11:	15PM
Examir		4a. Facility Name (If not Institution, gi	ve street end number)				4b. City, To	own, or Lo	cation of Death	4c. County			
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show		10a. State 10b. County		10c. City, Tov	vn or Location						1	Od. Inside	City Limits
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or 28	Ore	10e. Street and Number			10	. Zip Code			1	0g. Citizen of \	What Cour	ntry?	
th w	a	204 S. Southwoo	d Avenue			214	01		1	United	Stat	es	
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and ZIZID-UUZ be filed within 72 hours ital Hygiene. d other then "natural", event, tre Medical Exa	Completed	15. Decedent's E (Specify only highest gi	Education	168	Decedent's	Usual Occu	upation e du <i>ring</i> mo:	et of workli	na	16b. Kind ot B	usiness/In	dustry	
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should be not Mental marked umatic ev	To	Charles Owen						Fan	nie Wall	ker			
		19a. Intormant's Name/Relationship							I Route Number				1/01
Per Per		Bernice Owen (Wife)				wood A	Avenu	e Annap				1401
mit. Pages t er pertment of Hea portant: if item? y injury or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 i	☐Removai from State	20b. Piace o	of Disposition try, crematory	or other pl	ece)		Date	20c. Locetion -	City or To	own, Stata	
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sician: The certificate lirector, pag	Be C	25. Was cesa rafarred to medical					26 Plac	a of Death	(Check only on				
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Hospital 24 hours Funeral i	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of minar: On the basis of and manner sta	examination ar	e, death occur nd/or investiga	rrad at the t	ime, date ar opinion, das	nd place, a ath occurra	and due to the ce ad at tha tima, de	ause(s) and ma ata and place,	anner as s and due to	tated. tha cause)(s)
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		30. Name and address of person who								10-266-)	
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an			19e. Informent's Neme/Relationsh	nip (Type, Print)		19b. Meili	ng Address (Str	eet end Nur	nber or Ru	ral Route Numb	er, City or Town,	Stete, Zip	Code)
	nd 2 sith ar 27 is r trau		Virginia L. Kea	ting - Da	aughtei	4016	Jeffers	on St	reet.	Hvatts	ville, I	Marv1	and 20781
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Ba	Baltimore, M permit. Pages 1 and 2 Department of Health a Important: If item 27 is any lijury or other tra once.		21. Signisture of Furierer Service t	licensee	. N		2. Neme end Ad			s Fune	ral Home	. P.	Α.
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	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edicai	(Uneck only 2 Madical E	Physician: To the xaminer: On the b	best of my ki	nowledge, deet	n occurred et the	time, dete	end plece,	end due to the	ceuse(s) end me	enner as st	teted.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Carmella Petrini 1997 November 10:12 AM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthpleca (Stete or Foreign Country) 1□M XXF Yrs. Pennsylvania 177-03-5582 83 Oct 12 1914 Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Anne Arundel Annapolis 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 1 Walton Lane 21403 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 11. Maritel Stetus 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No if Yes, Give Yaer or Dates: 1□ Yes 2 No Specify: White 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Business Marina 17. Fethar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Thomas Schall Mary Rizzi 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Upshur Avenue Annapolis, Maryland 21403 Clara Petrini (Daughter) 20b. Piece of Disposition (Neme of cemetery, cremetory or other placeNov 4 1997) ate 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Duriai 2 ☐ Cramation 3 ☐ Removal from Stata 2 ☐ Connection 5 ☐ Other (Specify) Hillcrest Memorial Cemetery Annapolis, Maryland 22. Name end Address of Fecilityohn M. Taylor Funeral Home, Inc. 21. Signature of Funeral Sarvice Licensee 147 Duke of Gloucester St. Annapolis, MD21401 23a. Part 1. Enter the disease, or complications that coulled the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on a line. Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if any, leeding to Immadiate cause. Enter Underlying

Physician /Medical Examiner

burial-transit

and

Records, P.O. Box 68760.

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be ဂ္ဂ 10a. Stala

MD

Funeral

Director

tam 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Woolcal Examiner must be notified at

the Marylend

filed within 72 hours after deeth

permit. Pages 1 and 2 should be filed within Depertment of Heelth and Mental Hygiena. Important: If Itam 27 is marked other than any Injury or other traumetin.

Baltimore, Maryland 21215-0020

2 Completed Be 2 Medical Certification:

Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest		or es e consequence o	f):			
Part II. Other significant conditions con Chequie of tr				23b. Did tobacco use co	ontribute to the cause of death?	
Valvular & coron	anyheart	lisease,	Hypertersion	24e. Wes an autopsy performed?	24b. Were autopsy findings aveileble prior to completion of cause of death? 1 Yas 2 No	
25. Wes case refarred to medical exeminer?				eeth (Check only one)		
1 ☐ Yes 2 No	ospital: inpatient 2	ER/Outpetient 3	DOA Other: 4 Nursing	Home 5 ☐ Rasidence 8 ☐ Oth	nar (Specify)	
27. Menner of Deeth Naturel 5 Pending 2 Acoldent investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work? 1 Yes 2 No	28d. Describe how Injury occur	rred	
3 Sulcide 6 Could not be determined						
29e. Certifier (Check only one) Certifying Phys	tctan: To the best of my knoter: On the bests of examine end menner stated.	owledge, deeth occurre etion and/or investigeti	ed et the time, dete end plec on, in my opinion, deeth occ	ce, end due to the cause(s) end mo curred et the time, date end plece,	enner as steted. end due to the ceuse(s)	
29b. Signatura and title of certifier	Kinzar		9c. License number 05928	B Navew B	d (Month, Day, Year)	
30 Name and address of person who co	moleted cause of deeth /Iter	n 23a) /Tune Print)			1	

32. Registrer's Signature

who Davidson

2003 Medical Pkwy#100, Annapolis, MD 21401

State Registrar 31. Dete filed (Month, Dey, Year)

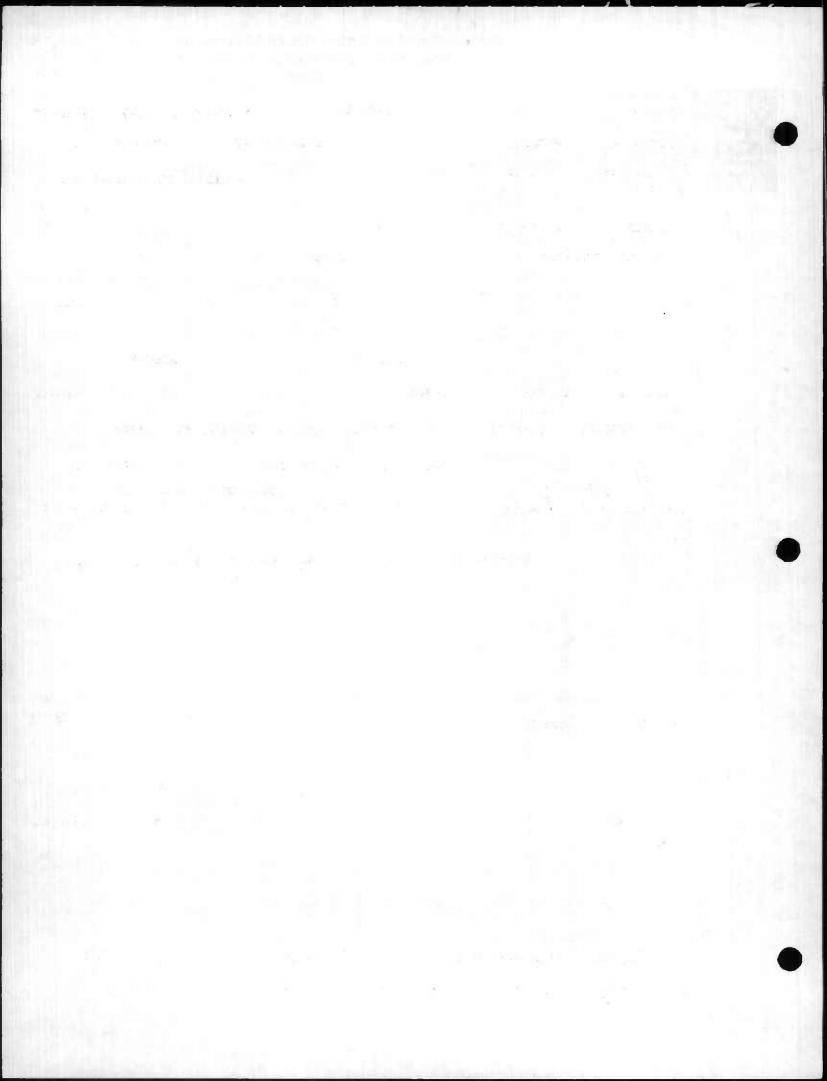
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To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics complately filled in by the funeral director;

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

n		1. Decedent's Neme (First, Middle, Las			Certificate of		2. Date of Dee		3. Tim Death	
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unerai irector	_		ex 7. Age	(In yrs. last birtl 72 y	irs. If Under 1 Year Months Days		8. Date of Birth (Month, Day APRIL	(, Year)	Birthplace (State or Fore Country) MARYLAND	
ygiena. Ner than "naturi n', the Medical		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. inside City Lim	
	ctor	MARYLAND ANNE	ARUNDEL		LINTHICUM				1 ☐ Yes 2 🔄	
	Director	10e. Street and Number 110 SYCAMORE ROA	D		10f. Zip Code 2.10	90		10g. Citizen of W		
	by Funeral	11. Meritel Status 1 Never Married 2 Married 3 Nover Married 2 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub	pecify Yes or No- o Rican, etc.)				
	Completed	15. Decedent's Edi (Specify only highest grad Elementery/Secondary (0-12)		+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of world)	king	16b. Kind of Bus		
	Be Co	17. Father's Name (First, Middle, Last)	0		EDUCATOR	18. Mother's Nam	ne (First, Middle,	EDUCAT Maiden Sumame		
	To B	ZACHARIA TUR	PIN	MEUSHAW		JESSI	E	CORNELIA DISN		
		19e. informant's Name/Reletionship (T)			Mailing Address (Street					
		LUCY POLLARD 20a. Method of Disposition	(NIECE)	20b. Place of	CAMBERLEY Disposition (Name of		TOWSON,		204 City or Town, State	
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Importa any inju ance.		21. Signatury of Funeral Service License	ess of Facility							
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		23a. Pm11. Enter the disease, or comp nock, or heart failure. List only o	olications that caused to one cause on each line	he death. Do no	ot enter the mode of dyl	ng, such as cardiac	or respiratory an	rest,	Approximate Intervel Between Onset and Death	
sician edicai miner		Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of):								
	ner			Due to (or es e co	onsequence of):					
physician and s the bunal-transit	edical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury c.								
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ched f	iysic	Part II. Other significant conditions con	ntributing to death but	not resulting in	the underlying cause gi	ven in Part i.		200	tributa to the cause of dec	
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should	Completed t						24a. Was a perfor		24b. Were eutopsy findin- available prior to completion of cause of death?	
ate has	Com						1 🗆 Y	es 2 No	1 ☐ Yes 2 ☐ No	
certificate rector, pa	Be	25. Wes case referred to medical examiner?	Hospital:		Ott	26. Place of Dea	U.S. Santian			
this ald	itlon: To	1 Yes 2 No ' 27. Menner of Death 1 Anatural 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Day	28b. Ti	me of 28c. Injury	4 LI Nursing H	ome 5 ☐ Resid 28d. Describe h	ence 6 Dother ow Injury occurre	r (Specify) Store	
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After this funeral di	Sertif		sician: To the best of	xamination end	deeth occurred et the til or Investigation, in my o	me, date and place opinion, death occur	, and due to the or rred at the time, o	ause(s) and man late and place, a	nner as stated. nd due to the cause(s)	
After this funeral di	edical Certification:	29e. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	and manner state					Od Date signed	(Month Day Vene)	
this aldi	Medical Certif	(Check only 2 Medicai Exami	and manner state		29c. Licens	se number		.ou. Date algineu	(Month, Day, Year)	
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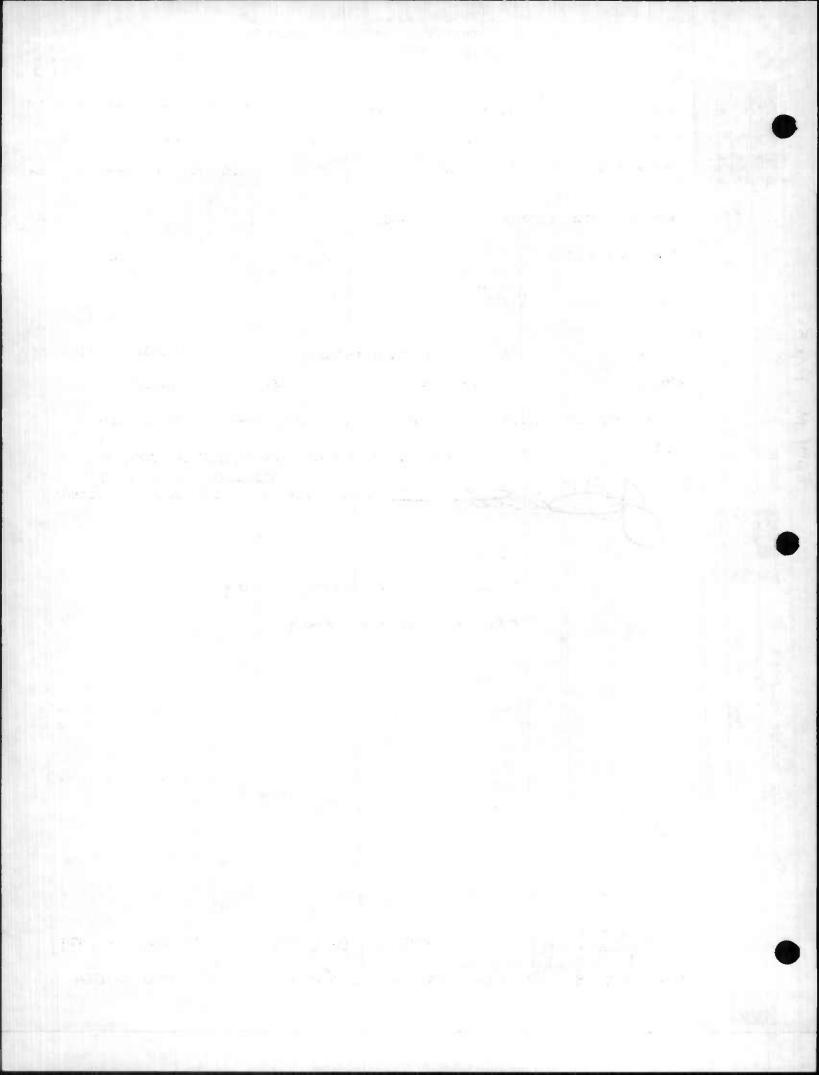
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Month 7.55 AM OUTOBER PARKS MAGDELENA /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Colera BURNIE Noory ARunisce THINE ARUNDEL HOSPITAL Months Days Hours Min. 8. Date of Birth Month, Day You 5. Social Security Number 226-12-1094 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 1□M 2፟MF 84 1913 WEST VIRGINIA Yrs. Director Usual Residence of Decedent with the Menyland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limita 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yea 2 XNo Directo MARYLAND ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 8204 W B & A ROAD items 23a 21144 U.S.A. Funeral 12. Was Decadent Evar in U,S. Armed Forces? 1 ☐ Yes 2 至 No If Yes, Give Year or Dates: Wes Dacadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Stetus 14. Raca - American Indian, Bleck, Whita, atc. 2 should be filed within 72 hours effer on and Mentel Hygiene.
Is marked other than "naturel", or item 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced "naturel", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Businaas/Industry (Specify only highest greda completed) Elementary/Secondery (0-12) Collage (1-4or 5+) NATIONAL PLASTICS, INC. 2 N/A MACHINE OPERATOR 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Be ROBERT HELMICK BELLE **JOHNSON** Peges 1 and 2 should he nent of Health and Ment 2 19a. Informant'a Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CALVIN EBBERTS 8204 W B & A ROAD, SEVERN, MARYLAND 21144 Important: If item 27 any injury or other tr (SON) Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from Stete MEADOWRIDGE MEMORIAL PARK 11/3/97 ELKRIDGE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of FacilitySINGLETON FUNERAL HOME, 21. Signature of SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 e. to complications thet causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. terval Betwe Onset end Deeth **Physician** /Medical Immediate Cause (Finel 268515 disease or condition resulting In death) Examiner Due to (or as e consequence of) Examiner CARSIOMYO FATH. MIL The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated eventa rasulting in death) Lest pue the buriel-tran Due to (or es e consequence of): MUCHFILLENC Box 68760. ed by the ettending physician detached for use as the bune Physician/Medical Due to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? been signed by t should be detach 1 ☐ Yes 2 ☐ No 3 Probably 4 Jonknown Records, à 24b. Wera autopsy findings available prior to completion of causa of death? Completed 24a. Wes an eutopsy performed? this certificate has 1 Yes 2 No 1 Yes 2 No Division of Vital Attending Physician: director, Be 25. Was case referred to medical axaminar? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Dey Year) Certification: 27. Manper of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death in by the 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours a
To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, end due to the cause(s) and manner es stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated. 29a. Certifier Medical Show in 29b. Signature and file of certifier 29c. License number 29d. Data signed (Month, Day, Year) MD 145149 E)COBEZ 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) GLEN BURNIE ONABAJO. B SRIVE 301 · GORPITAL 31. Date filed (Month, Dey, Yeer) 32. Begistrar's Signature State La Davidson-Randall £ 1997 Registrar 0

Parks

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.7

		1 Decided Nove (First Middle)	I and		Cert	ificate of	Death	I a a vi ta	Reg. No.	1 3	2016	
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/Medic		Addie Pierc						Nov.	4,199		7:00 P.N	
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		Prince George				Killadas 4 Maas	Cheverl	У	Prin	ce G	eorge's	
Funeral Director		579-44-5447	. Sex 7. A 1 □ M 2X F	ge (In yrs. las 90	Yrs.	if Under 1 Year Months Days	Hours Min.	*8. Date of B (Month, I	lirth Dey, Year) /07	9. Birthol Count Mary	eorge's leca (State or Foreign lry) land	
pua »	Director	Usuei Residence of Decedent 10e. Stete 10b. County		10c. City.	Town or Loca	ition				10	Od. Inside City Limits	
e Maryl			.G.		ndovei						Y□Yes 2□No	
きる。	Dire	10e. Street and Number				10f. Zip Code		10g. Citizen of Whet Cour			try?	
ath w	10	1803 Columb	ola Ave.			20	785		U.	S.A.		
Baltimore, Maryland 21215-0020 permit. Pagas 1 and 2 should be filled within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiene. Important: If them 27 is marked other than "neturel", or items 28e or 28e-1 show any injury or other traumetic event, tra Madical Examiner main be notified at once.	by Funeral	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forcas 1 Yes 2 di if Yes, Give Yaer or Datas:	?		as Decedent of I as, specify Cub	dispanic Origin? (Span, Mexicen, Puerto Specify:	specify Yas or No- to Ricen, etc.) 14. Race - American Indien, Bieck, White, etc. Specify: Black			etc.	
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215 bin 7	Completed	(Specify only highest of Elementary/Secondary (0-12)	college (1-4or	5+)	(Give kii life. DC	nd of work done NOT use retire	petion during most of work d)	king				
21 d with	E O	7th	Conlege (1-40)	34)	Domestic					te I	ndustry	
of the state of th	Be (17. Fether's Neme (First, Middle, La	•				18. Mother's Nam	e (First, Middl	le, Meiden Sumer	ne)		
/lai	To	George V	V. Pierce	,Sr.			El1	en Pla	ater			
short in man		19e. Informent's Neme/Relationship	(Type, Print)		19b. Mailing	Address (Street	end Number or Ru	ral Route Num	ber, City or Town	Stete, Zip	Code)	
M alth alth 227 is tree		Martina Colema	n/Niece		Same	as # 1	0 above					
Baltimore, semit. Pagas 1 an Department of Haal mportant: if Item 2 any Injury or other anse.		20e. Method of Disposition 1				ion (Neme of tory or other ple Mem . I		Dete / 1 1 / 0 '	20c. Location			
Itir P		21. Signetura of Funeral Service Lic	**	HUL		Nama and Addre		/ 11/3	Lando	ver,	Ma.	
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68760, ifficete be axecuted g physician and es the burial-transit	edicai	that initiated events resulting in death) Last Due to (or es e consequence of):										
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The lew requires that the daath cartificate be assocuted within 24 hours efter death. To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Completed by	SICK	SINUS 5	YNDROM	1E			24e. We	s en eutopsy formed?	con	re autopsy findings iliable prior to inpletion of cause leath?	
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Division or to the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Medical Certification:	(Check only 2 Medical Exp	Phyeician: To the best aminer: On the basis of end manner st	of exemination	n end/or inves	stigation, in my	ppinion, deeth occur	red et the time	e ceuse(s) end m e, dete end place,	and due to	the cause(s)	
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		DENNIS HAND, M.D					TTSVILLE,	MD 2	0781			
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Registr		NOV 1 0 199	7	rar's Signatur	Carole !!							

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State of Maryland / Department of Health and Mental Hygiene Q 7

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Boschian Palmer 4:30 Am Luigia November 7 1997 /Medical 4a. Facility Name (If not Institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's If Undar 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2♥F 89 Director 212-62-0073 Jan. 6, 1908 Italy Usual Residence of Decedent 10a. Stata 10h Count 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7900 Marlboro Pike 20747 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 M o tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 XXNo Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest greda completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th end Mentel Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumema) agas 1 and 2 should be nt of Heelth end Mente : If Item 27 is marked Domenica Paron Boschian Enrico 19a. Informant's Name/Reletionahip (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Frank J. Palmer/Husband 7900 Marlboro Pike, Forestville, Md. 20747 other 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Ramoval from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 11/10/97 Clinton, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Batween Onset end Death **Physician** /Medical Immediate Cause (Final Clarge disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Physician/Medicai P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the Congestive heartfactur, psudomonas 1 Yee 2 No 3 Probably 4 Unknown Records. þ Recurrent Gacho intertinal Completed 24a. Waa an autopsy 24b. Wera autopsy findings available prior to complation of cause of death? 1 ☐ Yes 2 No cartificata Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was casa referred to madical Be 26. Place of Death (Check only one) Hospital: 1 tnpatient 2 □ ER/Outpatlent 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Neturat 2 Accident 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif D24720 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) RAVINDER K. RUSTAGIM.D

G132 LANDOVER ROAD, Chevery, MD 20785 31. Data filed (Month, Dey, Year) State Registrar

Neverses 7 1979 H. Au-

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedant's Nama (First, Middle Last) 2. Deta of Deeth **Physician** Month Archie A. Pope November 9, 1997 8:00 am /Medical 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4316 Tuckerman Street Hyattsville Prince George's If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaer 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2□ F Months 578-07-9017 Yrs. 105 Director Sept. 4, 1892 North Carolina Usuel Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yas 2 No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zio Code 10g. Citizan of What Country? 4316 Tuckerman Street 20782 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Dates: 1917-19 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Marriad 2 Marriad 1 Yas 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Dacedent's Education (Specify only highest grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Car Salesman Private Industry 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meiden Sumama) Be William Pope Emma Armstrong 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Robert A. Pope - Son 210 Lombardy Court, Middletown, Maryland 21769 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 11/12/97 Silver Spring, MD 22. Nama and Addrass of Facility
Francis Gasch's Sons Funeral Home, P.A. 21. Signeture of Funeral Sarvice Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Entar tha diseasa, or complications that caused the death. Do not antar the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Deeth **Physician** Cardiac - Respiratory /Medical Immadiata Cause (Final diseasa or condition rasulting in deeth) Examiner Chronic obstructure lung B. Examiner Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Ceuse (Disaase or Injury that initiated avants rasulting in daath) Lest Dua to (or es e consaguance of): Physician/Medical Dua to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wera autopsy tindings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 25. Was case rafarred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Othar: 4□ Nursing Homa 5 Rasidance 8 □Othar (Specify) 1 Yas 2 No Certification: To 28a. Data of Injury (Month, Day Year) 27. Manpar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Netural 5 Panding 1 Tyes 2 No Investigation 2 Accidant 6 Could not be datarmined 3 Sulcida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicida 29a. Cartifian 1/25 Certifying Physician: To tha best of my knowledge, deeth occurred et tha tima, data and place, and dua to tha causa(s) and mennar as stated. Medical (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Data signad (Month, Day, Year) enwhen MID. D0052023 30. Neme and addrass of person who completed cause of deeth (Itam 23a) (Type, Print) 10403 Hospital Drive, Suite 103, Clinton, Maryland 20735 Maria Romero, M.D. 31. Data tilad (Month, Dey, Yaer) 32, Ragistrar's Signature State

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Registrar

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28a-f show

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylas Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural;, or items 23a or 28a-7 show any injury or other traumatic avent, in Medical Engineer must be notified as

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page 2 certificate

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The law requires that the death certificate be executed

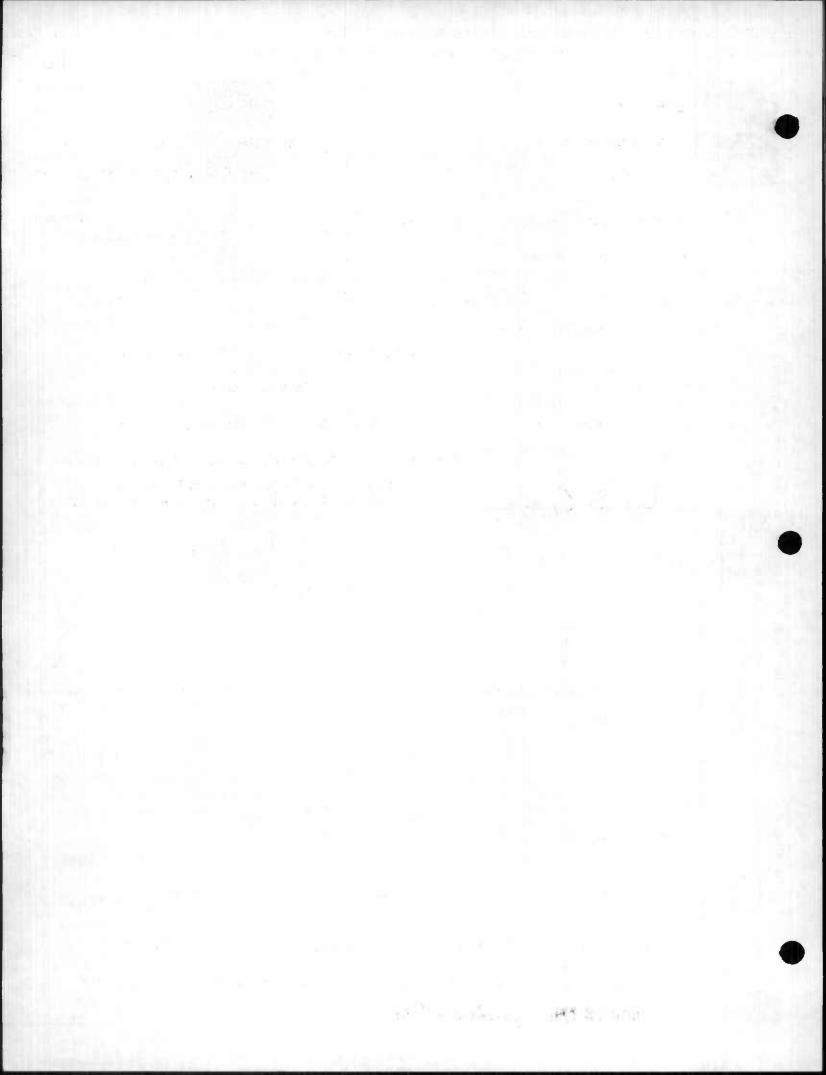
Box 68760.

P.O.

Records.

Division of Vital or Attending Physician:

Baltimore, Maryland 21215-0020



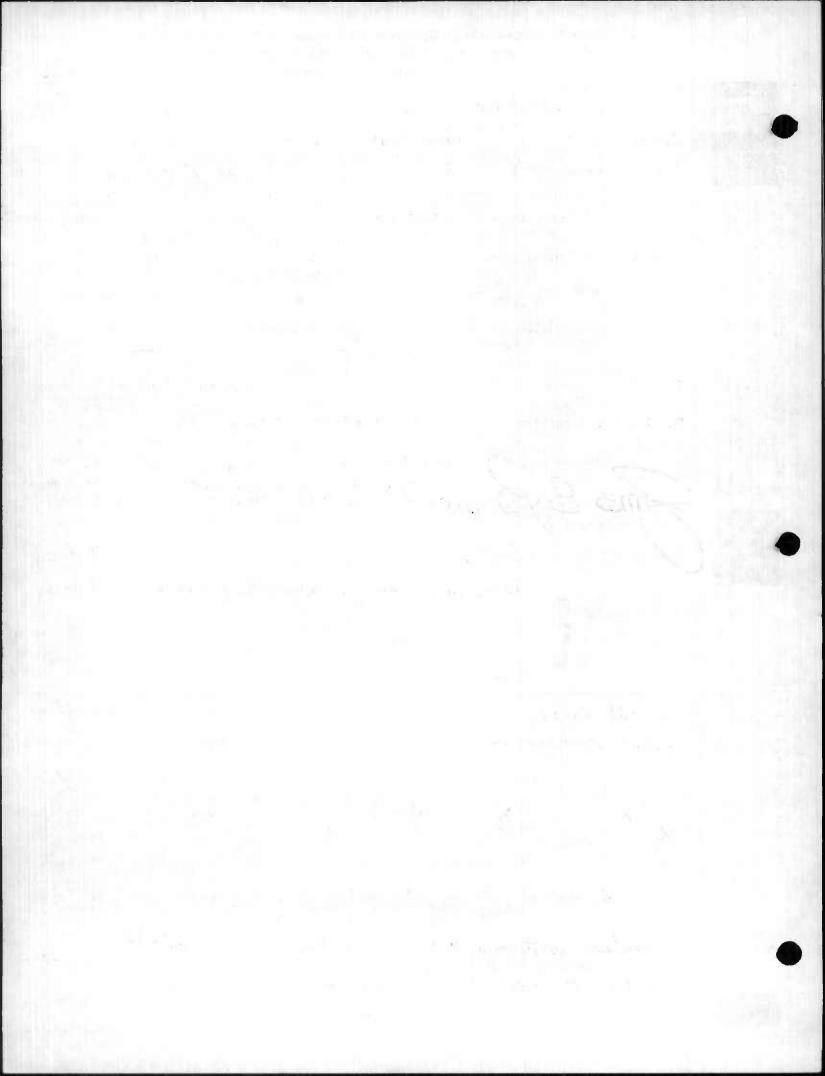
State of Maryland / Department of Health and Mental Hygiene

35819 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physiclan** Month Carolyn Rakestraw 9:20 PM 10 /Medical 4e. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hopkins Bayview Medical Center Baltimore Baltimore 5. Social Sacurity Number If Under 1 Yeer | if Under 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Sex 1□M 2XF Hours 75 212-12-4487 Director Maryland Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. insida City Limits 28a-f show the Medical Examiner must be nothed at MD Baltimore Baltimore City Director 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 6 1102 South Decker Avenue items 23a 21224 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American indlen, Bieck, White, etc. Pages 1 end 2 should be filed within 72 hours after inent of Health and Mertal tyglene.

ant: If flow 72 is marked other than "natural", or fee in yor other thaumalc event, the Medical Examine my or other thaumalc event, the Medical Examine. 1 Never Merried 2 Marriad 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ™ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Frederick Baum Marlene Cummings 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) P.O. Box 1096, Sedona, AZ Carolyn Wolf/daughter 20b. Plece of Disposition (Neme of cematery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burlai 2 ☐ Cramation 3 ☐ Ramoval from State Oct 28 permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 1997 21 Algorature of Europeal Service L 22 Nama and Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Seven and the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, seuse on each line. 495 Gov. Ritchie Hwy., Severna Park, MD 21146 Enter the diseesa, or compare the result of the compare the control of the contro **Physician** /Medical Immediate Cause (Finel days danger or condition Examiner Due to (or es e consequence of): Examiner Klebsiella pneumonia neumonia caused sician and burial-transit thet the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in deeth) Last Due to (or es e consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of): 88 P.O. I Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Breast cancer 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by Liver metastasec 24b. Were eutopsy findings evelleble prior to completion of causa of death? 24e. Wes en eutopsy performed? page 2 s 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer?

1 Yes 2 No director, Be 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. fnjury et Work? After 1 Neturel 5 Pending investigation i efter death. I Director: Aff 1 Yes 2 No 2□ Accident 6 Could not be 3 Suicide 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Straet end Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide • Funeral C Hospital edical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Fune completely fil 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Michaela. Wosterman, M.D. D52451 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) Michael A. Westerman Johns Hopkins Bayview Medical Center M.D. 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State NOV 06 1997 Februardon Devido Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35820 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Mary E. Riddick OUAM NOVEMBER /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Dea **Examiner** OSPITAL ANNE GLEN HRUNDEL URNIE NORTH EUNDEL If Under 1 Year If Under 24 Hrs Months Deys Hours Min. 5. Social Security Number Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 6. Sex Birthplece (State or Foreign Country) **Funeral** Months 1 M XX F 81 216-30-2613 Yrs Director October 8, 1916 Maryland Usual Residence of Decedent tha Maryland 10a. Stete 10b. County 10c. City, Town or Location r 28a-f show 10d. fnside City Limits Clinton Mary land Prince George's 1XXYes 2 No Director 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Maulcal Expriner must be 20735 U.S.A. 9604 Temple Hills Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiane. Important: If hem 27 is marked other than "natural", or any Injury or other traumatic awant. 1 Yes 2 No Specify: Black by 3XXWidowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Domestic Maid 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Mary Margaret Ford RIDDICK, James Lyles 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4802 Maui Street CLinton, Maryland 20735 Mrs. Dorothy E. Ford (Daughter) 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from Stete 11/12/97 Clinton, Maryland Forest Hills Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Neme end Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory elected, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physiclan** /Medical Immediate Ceuse (Finet disease or condition resulting in deeth) · UROSEPSIS week Examiner Due to (or es e consequence of): attending physician and for usa as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): P.O. Box 68760, Physician/Medical Demen TIA Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown signed t Records, by 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

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2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29e. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

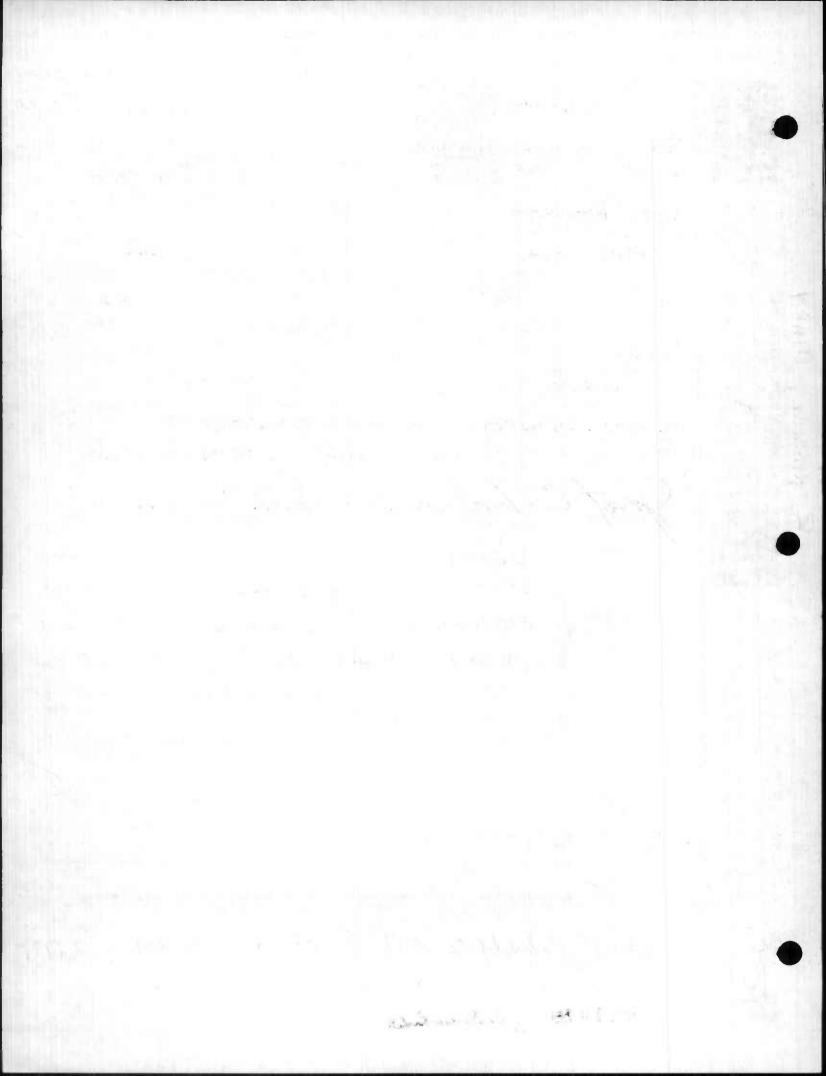
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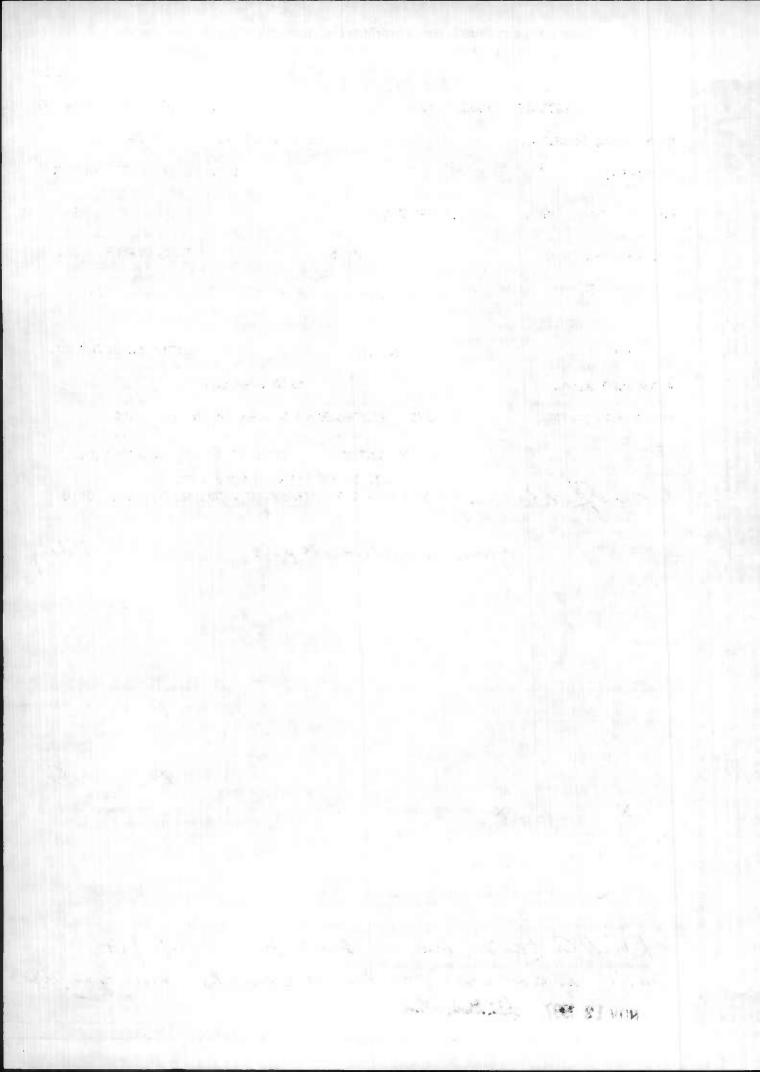
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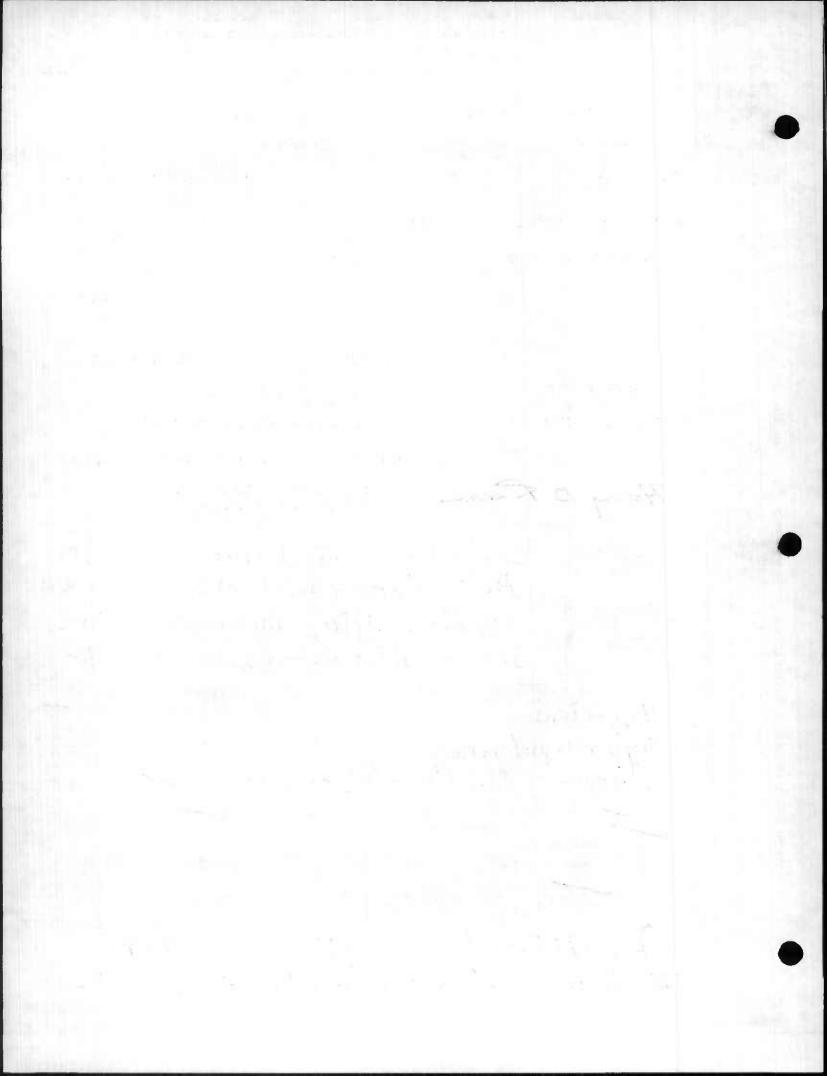
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			Certificate of Maryland / Department of			g. No.	35822
ľ	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
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	/land		10a. Stata 10b. County 10c. City, Town or Location				10d. Inside City Limits
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	r 284	Director	10e. Street and Number 10f. Zip Code)	10	g. Citizen of What Co	ountry?
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	To the Hospital or Attending F within 24 hours aftar death. To the Funeral Director: After completely filled in by the funer	Med	one) and manner stated.	nsa number			,
	0 1 × 0 0		29b. Signarthe and fittle of certifier 29c. Licar	1911	29	d. Dafa signed (Mont	n, Day, rear)
			Herry Dr.	1765		11/4/1	
	7. 1. 1		30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)	1. A	A		121401
	-01	•	31. Date filed (Mooth, Day, Year) 32. Registrer's Signature	19 pv	// VIV	MILLIAN W	7/ 21701
	Sta		NOV 0 € 1007				



State of Maryland / Department of Health and Mental Hygiene

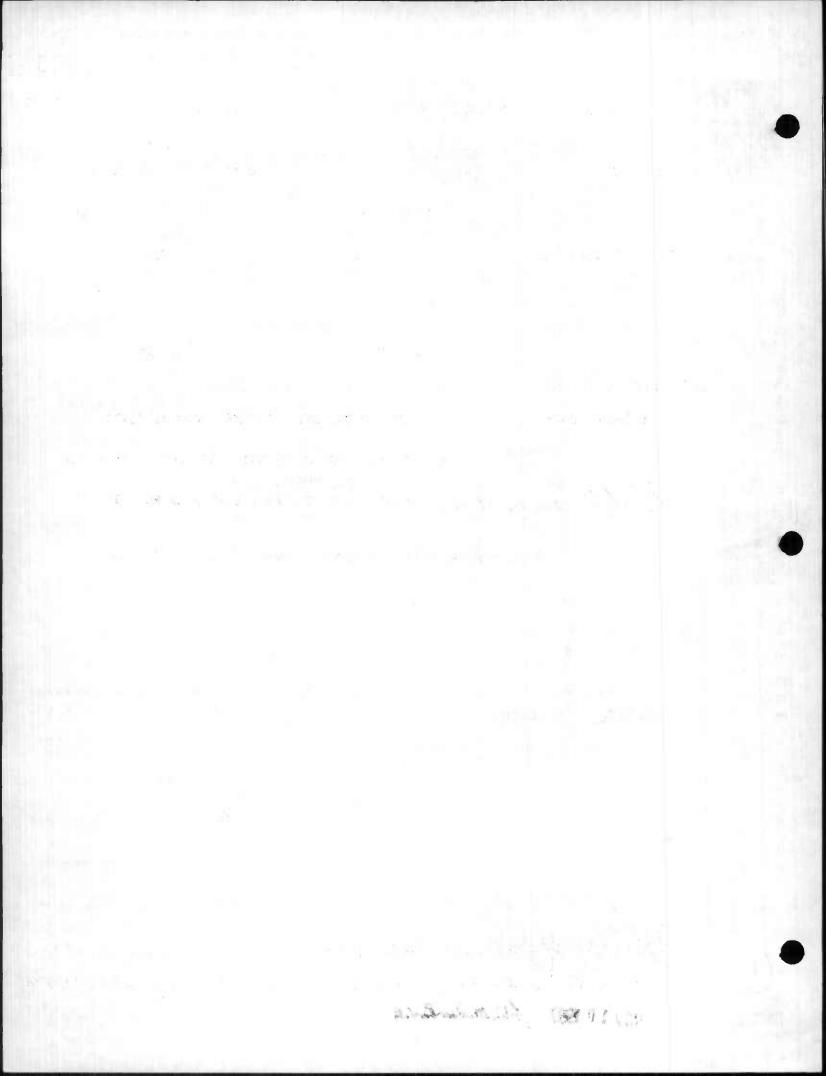
35823 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** PORTER 06:00 pm NOVEMBER 04, 1997 MAGGIE /Medical 4a. Facility Nama (If not institution, giva street and numbar, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARLBORD UPPER SHOLTON ST. PRINCE GEORGES 12610 | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month Day, Year) | 9-11-11 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country)
 ALABAMA **Funeral** 10 M 2 F 254-05-1233 Yrs. 86 **Director** Usual Residence of Decedent with the Merylend 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits ALA SHORTERVILLE 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RT. 1 SHORTERVILLE 36373 USA death Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ဩ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: BLACK by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC PRIVATE Maryland 17. Father's Nama (First, Middle, Last) . Pages 1 end 2 should be fill ment of Health end Mental Hant: If Item 27 Is marked oth lury or other traumatic even 18. Mother's Name (First, Middle, Maldan Sumame) Be CHARLIE LEE PORTER DICY CLARK 19a. tnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL REYNOLDS COFFEE 12610 SHOLTON ST. UPPER MARLBORO MD 20774 Baltimore, 20b. Piace of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date MBurial 2 Cremation 3 NRemoval from State permit. Page Depertment o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) OLD FRIENDSHIP AME CH CEMT11-8-97 SHORTERVILLE ALA 22. Name and Address of Facility POPEFUNERAL HOMES 21. Signature of Funerel Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. 5538 MARLBORO PIKE FORESTVILLE MD 20747 Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final . HYPERTENSIVE ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed bunel-transit Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, ettending physician Physician/Medical the Dua to (or as a consequence of): signed by the e Part II. Other stgniftcant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETEC MELLITUS Division of Vital Records. þ 24b. Were autopsy findings aveileble prior to completion of ceusa of death? Completed 24a. Was an autopsy performed? peeu hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificete Attending Physician: Be director 25. Was case referred to medical 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home P ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After 5 Pending investigation 1 Natural death. 2 Accident 1 Yes 2 No ours effer death heral Director: A filled in by the f 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Hospital 624 hours 8 To the Hospital
within 24 hours a
To the Funeral E
completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner as stated.

Madical Examinar: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and manner stated. 29e. Certifier Medical 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) PME NOVEMBER 06, 1997 and address of person who d (item 23a) (Type, Print) 3001 HOSPITAL DRING, CHEVERLY, MARYLAND 20 785 GOLVE JR MARIO MO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

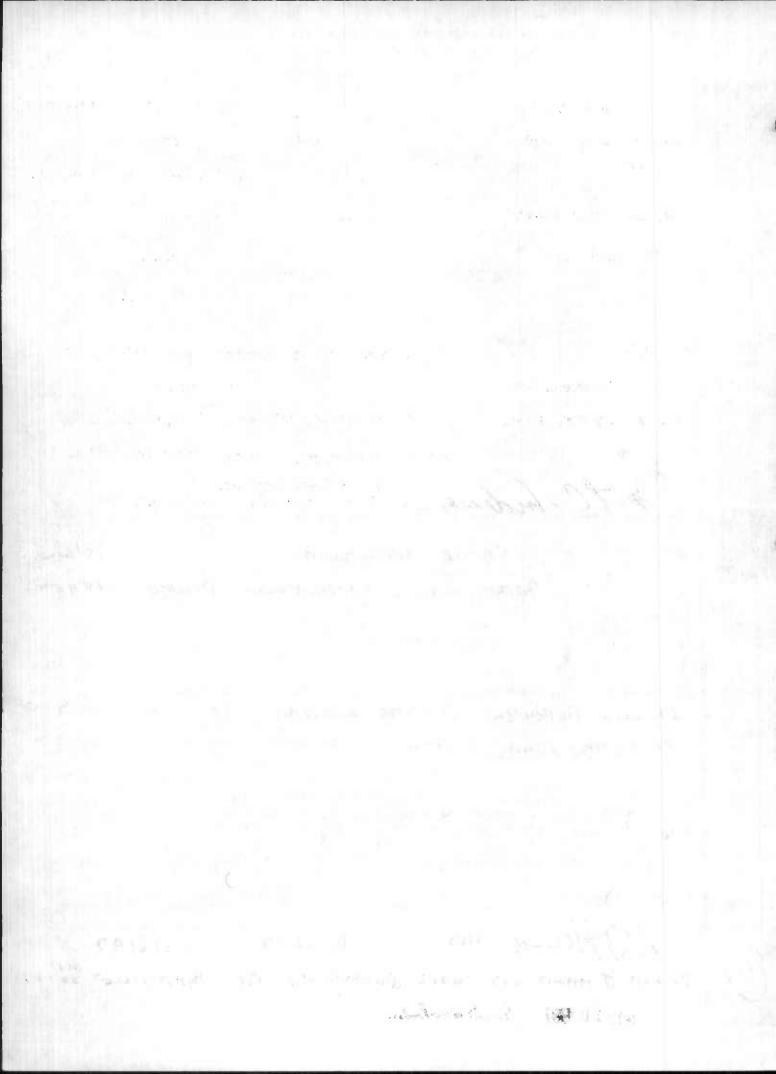
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Registrar

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	S	State of Maryland / D	Department of F Certificate of	Health and N Death		giene 9 °	7 3582	4	
Physician /Medical	Decedent's Name (First, Middle, Last) Jarma W. Sil	ver	- 1	1017	2. Date of Dea		3. Time of [97 10:47]		
Examiner	4e. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or L					
	Doctor's Community Hosp		Miladad Vasa	Lanham			George's		
Funeral Director	077 01 0007	7. Age (In yrs. last birth	hday) If Under 1 Year Months Deys		8. Date of Birth (Month, Day April 1,	7. Year) 1940	g. Birthplace (State or Country) Washington, I	Foreign D.C.	
Mand Am	Usuai Residenca of Decedent 10e. State 10b. County	10c. City, Town	or Location				10d. Inside City	y Limits	
The Maryla 28s-f ahor notified at	Maryland Prince Georg	e's	Greenbelt				XX Yes	2□No	
	10e. Street end Number		10f. Zip Code			10g. Citizen of W	Vhat Country?		
23 marth	7010 Greenbelt Road	W	145.00	20770		U.S.A.			
020 urs after death with alt, or thems 23e or commerce must be by Funeral DI	1 Never Married 2 Married	Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☼ No		ecity Yes or No- Rican, etc.)		e - American Indian, k, White, atc. :: B1ack		
	15. Decedant's Educati	on 16a.	Decedent's Usuel Occup	petion	to a	16b. Kind of Bu	siness/industry		
I 21215-0 sed within 72 ho years. See them 'neuturn' to the Medical.		Collaga (1-4or 5+)	(Give kind of work done life. DO NOT use retire						
- STEET O	12th grade 17. Fether's Name (First, Middle, Last)		Emergency Adm	itting Supe			ill Hospital		
yland yland Mental I Mental I	Clarence L. W	hite		TO. INIOITIES TYAITI	Bernice I		α/		
~ # # # # #	19e. Informant's Name/Relationship (Type,		Mailing Address (Street					1	
- A Delica	Mr. Paul M. Silver, II		705 Riverdale	Road #202 N		Iton, Mary	yland 20784		
Baltimore Somit, Pages 11 Soprament of He mportant, if them my injury or other abide.	20a. Method of Disposition 1 Buriel SCoremation 3 Remote 4 Donation 5 Other (Specify)	cemetery	Disposition (Name of y, crematory or other pla ake Crematory,		Date 1/7/97		e, Maryland		
Baltimol permit. Pages December of important if it any Injury or e	21. Signatura of Funeral Service Licensee	//-	22 Name and Addre				00010		
CL	23a Part / Enter the disease, or compliceti	ons that caused the death. Do no		Place, N.E			Approximate		
Physician	k, or heart failure. List only one c	ause on each line.					Onset and De		
/Medical Examiner	Immediate Cause (Final disease or condition rasulting in death) a.	CARDIAC 1	ARRHYTHUM	uA			15 m	L	
<u> </u>		Due to (or as a c		4-0.	2	1	10214.5		
'60, be executed ician and burial-transit	0	NTENIO SCLENO		10011 aca	n Pi	SEASE	1096	1119	
18760, cate be execut only sician and the bunal-trandical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.								
physical of the cate	that initieted events resulting in death) Last	Due to (or as a co	onsequence of):						
Box 6 eath certific attending p for use as	d								
Geath death of for the stician	Pert ii. Other significant conditions contribu	uting to death but not resulting in	the underlying cause give	ven in Part I	23h. Did to	obacco use con	ntribute to the cause of	f death?	
of Vital Records, P.O. Box 6 Physician: The law requires that the death certificates conting this certificate has been signed by the attending firal director, page 2 should be detached for use as TO Be Completed by Physician/Mei: To Be Completed by Physician/Mei: To Be Completed by Physician/Mei		_					3 Probably 4		
dS, ires the signed about d by	END STAGE RE	476.47			2507111015		A41 141		
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	END STAGE REI	YAL DISENS	E		24a. Was a perfor	med?	24b. Wera autopsy fin available prior to completion of car		
The law page 2:					10Y	es 2 No	of death?	No	
f Vital I yelclen: The sis certificate director, pag To Be Co	25. Was casa referred to medical axaminer?			26. Piaca of Deati			10163 2431	***	
Of V Physic this ce ral dire	1 ☐ Yes 2 ☐ No Hosp	1 Inpatient 21 ER/Out		4 LI Nursing Ho	me 5 Resid	enca 6 Othe	or (Specify)		
Affect funeration:	1 Natural 5 Panding	8a. Date of Injury (Month, Day Year) 28b. Ti	jury Wor	ry at rk? Yes 2 ☐ No	28d. Describe h	ow Injury occurre	ed		
Vision Attended the option of	2 Accident Investigation 3 Suicide 6 Could not be	8e. Pleca of Injury - At home, ferr			28f. Location (S	treet and Numbe	er or Rural Route Numbe	er.	
Division C tal or Attending P rs after death all Directors After to led in by the funers Certification:	4 Homicide determined	 Pleca of Injury - At home, ferr building, etc. (Specify) 			City or Tow	n, State)			
n 24 hound n 24 hound n 24 hound he Funer pletely fill	Check only 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and and menner steted.	death occurred at the tir for invastigation, in my o	me, data and place, opinion, death occurr	and due to the c ed at tha tima, d	ause(s) and mar late and placa, a	nnar as stated. ind due to tha cause(s)		
To the comp	29b. Signeture end till of central	1 m	29c. Licens		2	29d. Date signed	(Month, Dey, Year)		
(F)	16/ Man	W.		4899		11/6	197		
13/	20. Name and eddress of person who complete the services of th	eted cause of death (Itam 23a) (T	Type, Print) QUEENSS	Buny P	'u. H	HATTSU	ILLE 20	781	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sell						



State of Maryland / Department of Health and Mental Hygiene 97

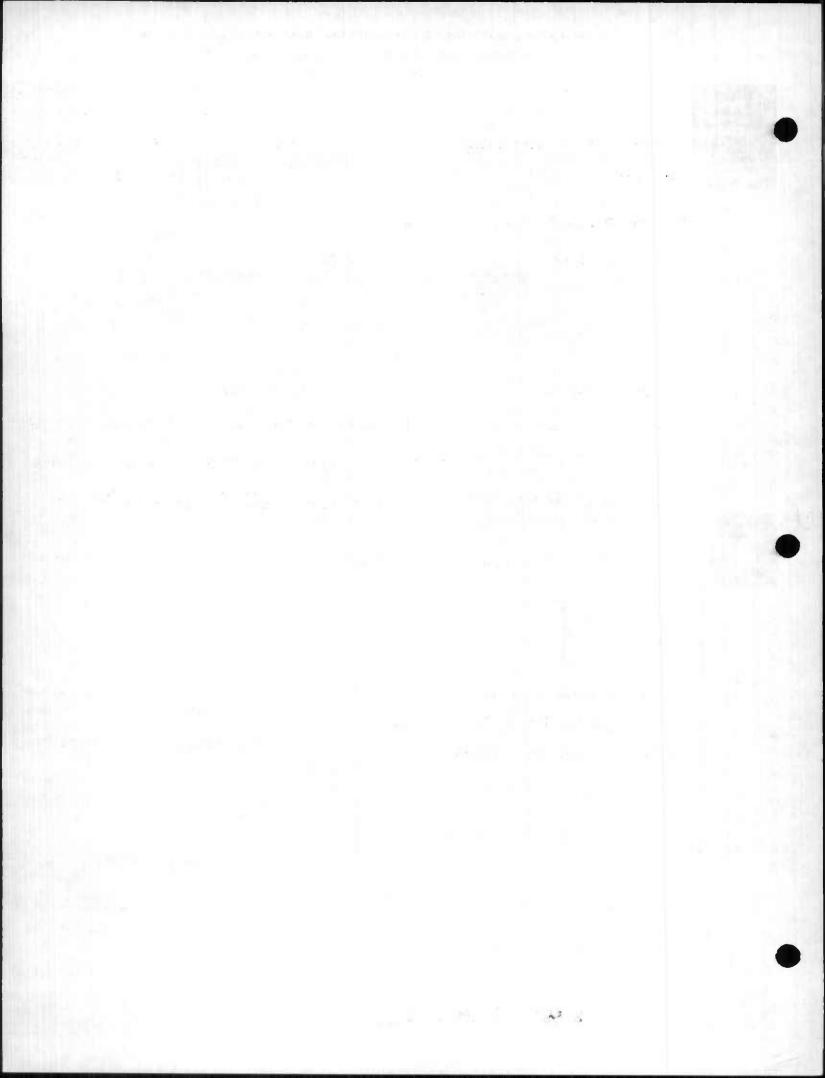
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						Certi	ficate o	of De	ath			Reg. No.		'	00020
			1. Decedant's Nama (First, Middle,	Last)							2. Data of De	ath			3. Tima of Death
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1	/Medi Examii		4a. Facility Nama (If not institution,	give street and number	7)			4b. C	City, To	wn, or Lo	ocation of Daat			of Death	
	Exami				4/ 6	/			/	0.1	rel			P6	PRINCE
4-	Funeral			91000 / Sax 7.A	iga (In yrs. last bi	irthday)	If Undar 1 Ya	aar If	Undar		8. Data of Bir	rth			GEORGE'S
	Director		578-32-7856	1□M 2 7 F	77		Months Da	ys H	Hours	Min.	(Month, De	ay, Year)	920	SOUTI	place (State or Foreign htry) H DAKOTA
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	the Merylan 28a-f show	Director		E GEORGE'S	HYATT										
	with the Meryland a or 28a-f show Lbe notified at	급	10e. Street and Number				10f. Zip Cod	la				10g. Citi	izen of \	What Cour	ntry?
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3	Merke	2	WILLIAM YANN					M	ART	HA S	EEFELD				
Maryland	d 2 should th and Mer 7 is marke traumatic		19e. Informant's Name/Ralationship	(Type, Print)	191	b. Mailing A	Address (Str	eet end	Numbe	er or Run	al Route Numb	er, City o	r Town,	State, Zip	Code)
	f Health them 27 other t		STEPHEN SILVIOUS	, NEPHEW					DRI	VE,	MT. AII	RY, M	IARY	LAND	21771
OF	If of H		20a. Mathod of Disposition 1 ☒ Burial 2 ☐ Cramation 3	□Removel from State	20b. Place o	of Disposition 1 <i>ry, cremat</i> e	on (Name of ory or othar	place)			Data	20c. Lo	cation -	City or To	own, State
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	Examiner		disease or condition resulting in death)	a. HCU-		190	CAN	・ソー	/]		11417	1/	110	,,,	I WIZEK
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ם			27. Manner of Death 1 ➡Natural 5 ☐ Panding	28a. Data of fnj (Month, Di	ury 28b.	Tima of Injury	28c. Ir	njury at Work?			28d. Describe	how Injur	y occur	red	
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<u>></u>	er de recte	t t	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of in	njury - At homa, fa	arm, straat,	, factory, offi	се			28f. Location (City or To	Street an	d Numb	er or Rura	Route Number,
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	To the Hospital or Attend within 24 hours after dealt to the Funeral Director: completely filled in by the	edicai	one) 2 Medical Ex	aminar: On the basis of and mannar s	tated.	avor invast	ugation, in m	y opinio	лі, даеі	ui occurr	ed at tha tima,	uete and	piace,	ano dua to	uia causa(s)
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-/	201		30. Name and address of person wh	o completed causa of	daath (item 23a)	(Type, Prin	nI)	^		_/	0	1	A 1		1
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State of Maryland / Department of Health and Mental Hygiene

35826

						Cer	tificate	e of	Death		Re	eg. No.			
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	sician edical	ı	Ervin D. J. St	einbach								r 8, 19		3:2	5 am
	miner	4	a. Facility Name (If not institution, gi	va street and number)					4b. City, Town,	or Locatio	n of Death	4c. County	of Death		
			Manor Care Nu						Large		-	Princ			
Fune Direct		1		Sex 7. Age	(In yrs. lest bi	Yrs.	If Under Months	1 Yea Days		Vin. (oate of Birth Month, Day, V. 2,			place (State ofry) Souri	or Foreign
anyland		1	0a. State 10b. County		10c. City, Tov	vn or Lo	cation						1	Od. Inside	City Limits
Man	ţ	1	Maryland Prince (George's	Larg	go								1 □ Ye	s 2 🖾 No
h with the	al Director		0e. Street and Number 600 Largo Road				10f. Zip	Code	72		10	0g. Citizen of \		ntry?	
ire, Maryland Z1Z15-UUZU s 1 end 2 should be filed within 72 hours after death with the Maryland f Heelth and Mental Hyglene. Item 21 is marked other then "neturel", or items 23e or 28e-7 ehow then treumatic event, the Wedest Exertifier must be notified as	by Funeral		t. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Deced f Yes, spec i ☐ Yes 2		Hispenic Origin ban, Mexicen, P Specify:	? (Specify uerto Rica	Yes or No- n, etc.)		ck, White,		
5-C 72 h 72 h	Completed		15. Decedent's E (Specify only highest gr	ducetion rada complated)	168	. Deced	ient's Usue kind of wor	l Occu	ipation a during most of ed)	working		16b. Kind of 8	usiness/in	dustry	
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Maryland d 2 should be file th and Mental Hy 7 is marked oths treumatic event	Be		7. Father's Name (First, Middla, Las							Kerc		Neidell Suman	ia)		
Ty d Me	2		Bruno Steinbac 9e. Informant's Name/Relationship		10	h Mailin	a Addross	(Ctro	et end Number o			City or Tours	State 7ii	Code)	
d 2 sign and and and and and and and and and an			Donald E. Steinb						eet, Mou						2-10/4
Heelth Heelth Hem 27 i		-	Donard E. Sterno	a.c.i - 30ii	20b. Place c							20c. Location			2-194
Daltimore, N permit. Pages 1 end Department of Heelth Important: If Item 27 any injury or other tr			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont	ify)		hofi	E Ceme	ete	ry	11/		Hillsb			ouri
Demit Departiment important	9000	80	1. Signature of Funeral Server Lice	RONDSON		Fı	ranci	s G	ess of Facility asch's imore A	Sons	Funer	al Home	, P.	A.	781
Physicia /Medic Examin	ai er	10	mmediate Cause (Final lisease or condition esulting in death)		ARY ART			ASE					F	Onset an	
ecords, P.O. BOX 68/60, law requires that the death certificate be associated es been signed by the ettending physician and 2 should be detached for use as the build-transit			sequentially list conditions, eny, leading to immediate euse. Enter Underlying Lause (Disease or Injury hat initiated events esulting in death) Last	C	Due to (or as a										
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es the igned be det	by	-	CHRONIC OBSTRUCT	IVE PULMONA	AKY DIS	LAS.	E			_			T		
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r e fe	E O										1 🗆 Y	es 2 No	1	☐ Yes 2	□ No
Of Vital Physician: The this certificata ral director, pag	Be		5. Wes cese referred to medical examiner?						26. Place of	Deeth (Cl	neck only on	a)			
- 5 00			1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2 ER/C	Outpatien	nt 3□ DC	DA C	ther: 4 🖾 Nursi	ng Home	5 Reside	ence 6 DOth	ner (Speci	ity)	
	Certification:	2	7. Manner of Death 1 Naturel 5 Pending 2 Accident investigate		Year) 28b.	Time of Injury	M 2	8c. Inj W 1[ury at ork? ☐ Yes 2 ☐ No			ow injury occur			
DIVISION at or Attending s after death. it Director: After ed in by the fune	Sertific		3 ☐ Suicide 6 ☐ Could not 1 4 ☐ Homicide determined		ry - At home, f . (Specify)	farm, str	eet, factory	, offic	9	28f.	Location (Si City or Town	treet end Num n, Stata)	ber or Rui	al Route N	ım <i>ber</i> ,
DIVI: To the Hospital or Att within 24 hours after d To the Funeral Direct	edicai (2		hysician: To the best o miner: On the basis of and manner sta	exeminetion a										e(s)
To the Howithin 24 To the Fu	Me	2	9b. Signature end title of certifier	- 3					nse number		2	9d. Date signe)
(1)			> HBNOY		anth flares and) (T:			2318			11-1			
4			0. Name and address of person who R'G-BH0JRA			n Mg	poli	5 1	24.#1	0 - 1.	olade	nshwr	5,m	D70	710
	State istrar	3	1. Dete filed (Month, Day, Year) NOV 12 13	97 Julia d	Hudlen	Park	Щ								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First Middle Lest) 2. Date of Death 3. Time of Death Shorter November 9 1997 11:24a.m. 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lanham Prince George's Doctors Community Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1⊠M 2□F Yrs. 577-16-6158 5, 1921 Maryland Apr. Usuel Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland | Prince George's Greenbelt 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 51 J Ridge Road 20770 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian, Biack, White, etc. 1 Never Married 2 Married 1 X Yes 2 No 1942-If Yes, Give 1946 Year or Detes: 1946 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilaga (1-4or 5+) Baker Baking 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surname) Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Shorter - Spouse 51 J Ridge Road, Greenbelt, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locetion - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/97 Brentwood, Maryland Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis Gasch s Sons Funeral Home, P.A. d. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final NIMYXED disease or condition resulting in death) Congestion Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarfying Cause (Disaase or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) NEGMONIA Due to (or as a consequence of): n1/10~ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 42 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese refarred to medical 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIda 12 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Baltimore, Maryland permit. Peges 1 and 2 s
Department of Health or
important: if Item 27 1s
any injury or other trau **Physician** Box 68760. Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

should be filed within 72 hours effer ond Mantal Hygiena. marked other than "natural", or iter

Peges 1 and 2 should be 1 nent of Health end Mantal I int: If Item 27 Is marked of

/Medical

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Physician/Medical

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Completed

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1 Natural

3 Suicide

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29a. Certifian

Medical Certification:

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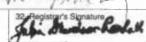
or Attending Physician: The law requires that the deeth certificeta be axecuted been signed by the should be detached certificate Aftar this death. i Director: / ed in by the To the Hospital or At-ithin 24 hours aftar of the Funeral Direct

> State Registrar

omplataly

31. Date filed (Month, Day, Year)

30. Name and address of person who



d cause of death (Item 23a) (Type, Print)

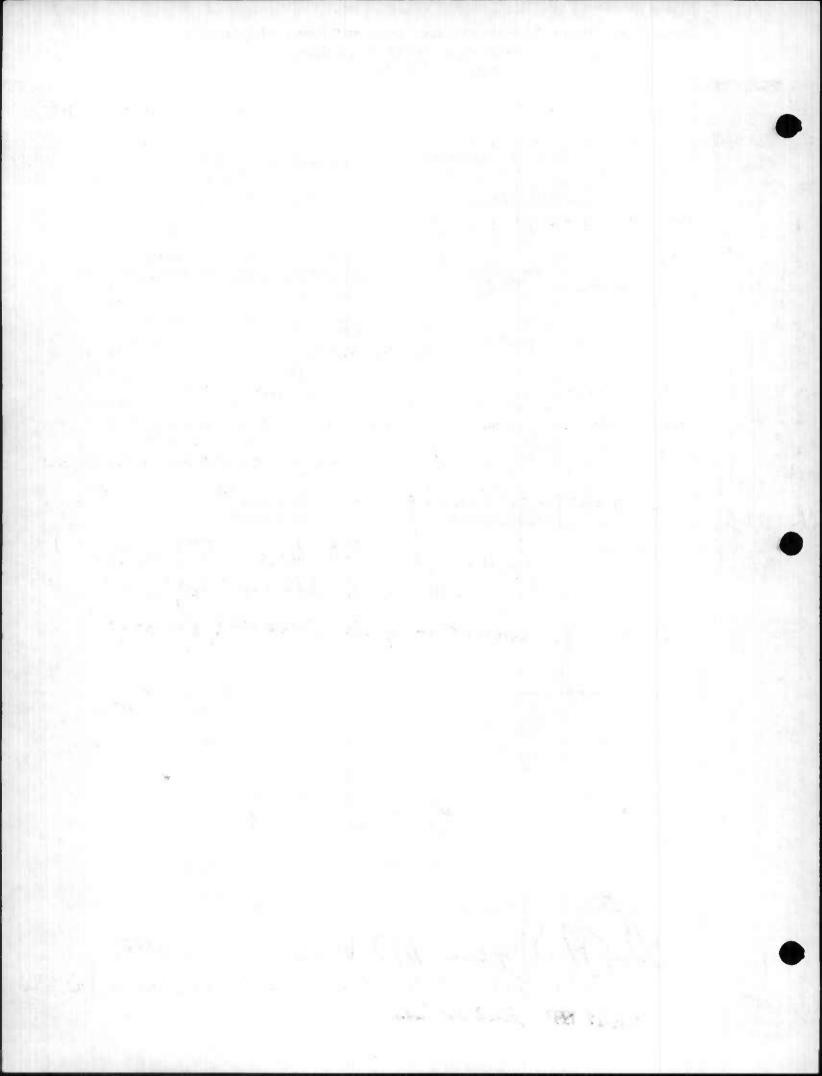
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toget facility.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 7 3 5 8 2 8

		Decedent's Neme (First, Middle, Last)			tificate of	Doutin	2. Dete of Dee	th		3. Time of Death
Physici		Marie A. Schwa	rtz				Month	Dey	Year	
/Medic		4a. Fecility Name (If not institution, give s			1	4b. City, Town, or L		er 9, 19		6:55 pm
Examir	er						obation of Bootin			
		Doctor's Communit 5. Social Security Number 6. Sex		. lest birthday)	If Under 1 Year	Lanham If Under 24 Hrs.	9 Date of Birth	Princ		
Funeral Director			M 212 F	Vre	Months Days		8. Dete of Birth (Month, Dey	Year)	9. Birthpia Countr	ca (Stete or Foreign
Director		Usual Residence of Decedent	5	/			Mar. 29	, 1940	wash1	ngton, DC
lend wo		10e. Stata 10b. County	10c. C	ity, Town or Lo	cation				100	d. inside City Limits
death with the Marylend ms 23a or 28a-f show Linust be notified at	ō	Maryland Prince Ge	orge's	Lanham						1 Yes 2 No
28.4 1000	Director	10e. Street end Number	orge 3	Dannam	10f. Zip Code			Og. Citizen of W	That Country	10
with with		FF07 7F41 A			5 0.					y.
ns 23s	Funeral	5507 75th Avenue	2. Wes Decedent Ever in U	10 10 10	2070		anife Van ar Na	U.S.A	- Amarica	a ladica
ural', or items	5	1 Navar Married 2 Married	Armed Forcas?	7,3. IS. V	Yes, specify Cut	Hispenic Origin? (Sp sen, Mexican, Puarto	Ricen, atc.)		k, Whita, at	
	by F	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No if Yes, Give Yaer or Detes:	1	☐ Yas 2 No	Specify:		Specify:	Whit	
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	Completed	15. Decedent's Educ (Specify only highest grade	com <i>pleted)</i>	(Give	ent's Usuei Occu kind of work done	pation during most of worked)	king	16b. Kind of Bu	siness/Indu	stry
than the M	du	Elementery/Secondery (0-12)	Coilege (1-4or 5+)		ical Wor			Privat		***
nt, m		12 17. Fathar's Neme (First, Middle, Last)		Cler	ical wor		- 45-14-14-14			tor
arked of	Be					18. Mother's Nem	e (First, Middle, i	Melden Sumemi	9)	
atic and	T _o	Albert Lasanska				Margar	et Voll	and		
la m	9	19e, informent's Name/Reletionship (Typ	e, Print)	19b. Meilin	g Address (Stree	t end Number or Ru	rel Route Number	r, City or Town,	Stete, Zip C	Code)
n 27		Paul L. Schwartz -				enue, Lanh	am, Mar	yland 2	20706	
f item 27 i r other tr		20a. Mathod of Disposition	20b.	Plece of Dispos	sition (Neme of netory or other ple	oce)	Dete	20c. Location -	City or Tow	n, Stete
nt: II		1 ☑ Burial 2 ☐ Cremetion 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify)	moval from Stete	/	coln Cem		1/14/97	Brentwo	od M	arvland
Department of Haalth end Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, the M QDCB.		21. Signatura of Funeral Service License			Neme end Addre		1/17///	DICHEWO	ou, n	aryrand
impo any ir		100	- 1 %	A F1	cancis G	asch's Son	ns Funer	al Home	, P.A	
		220 Bottl Ester the disease or complice	J. 2300			imore Ave				
		23e. Pert1. Enter the disease, or complic shock, or heart fellure. List only one	ceuse on each line.	un. Do not ente	or the mode of dy	ing, such es cerdiec	or respiretory err	est,	10	Approximete Interval Between Onset and Deeth
ysician Iedicai		Immediate Course (Fig. 1)	.0	0- 1	m A	- L	. 11	-1		Diser and Deeth
aminer		Immediate Cause (Finel disaese or condition resulting in deeth)	Levelrul	1700	11/1/1	es Tusis	with	Janu	Dic.	e
		resulting in deetin)	Due to (or a conseq	uence of): g	L	101	H		
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an e		Sequentially list conditions, if any, leading to immadiate ceusa. Enter Underlying Ceusa (Disease or Injury	1		111	bread	15	111	2)	
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D 65	-	resulting in death) Lest	2010(J. 100 0.1/1.			6		
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for	Physician/N									
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funeral	20	1 DNeturai 5 ☐ Pending	28e. Dete of injury (Month, Dey Year)	injury	28c. inju Wo		LOG. Describe N	JA IIIJUTY OCCUPTE		
by the	#	2 Accidant investigation 3 Sulcide 6 Could not be			M 1	Yes 2 No				
Director: After in by the fune	Ö	4 Homicide determined	28e. Plece of Injury - At h building, etc. (Special	ome, ferm, stre	et, fectory, office		28f. Location (Si City or Town	treet end Numbe n, Stete)	or Or Rural F	Route Number,
b B	tifica	_					1111			
	Certification:		cian: To the best of my kno	wiedge, deeth	occurred et the ti	me, dete end plece,	end due to the c	euse(s) end mar	ner as stet	ed.
4 2		29e. Certifier Certifying Physi	r: Un the basis of examine	non end/or inv	estigetion, in my	opinion, deeth occur	red et the time, d	ete end plece, a	nd due to th	ne ceuse(s)
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completely	edicai	one) Medical Examine	end manner steted.	111	29c. Licens	se number	2	9d. Dete signed	(Month, De	
To the Funcompletely	edicai	29b. Signature and the of certifier	ay On	111) DIC	se number	2	9d. Dete signed	(Month, De	
Adhin 24 hours effer To the Funeral Directory filled in the	edicai	one) Medical Examine	ay On	-) DIC	0085		11/11/9	X.	ay, Year)
	Medical	29b. Signature and little of certifier 30. Name and address of person who con	pleted cause of deeth (Iter	TCHEU) DIC	0085		11/11/9	X.	
Highin 24 hours of the Funeral I completely filled	Medical	29b. Signature and the of certifier	ay On	TCHEU	DIC VILLE	0085		11/11/9	X.	oy, Year)



Physicia /Medic	an al	5. P.G.C. 11–18–9 1. Decedent's Name (First, Middle, La: GEORGIANNA ELS 4e. Fecility Name (If not institution, give	st) IE SPRIG		Certificate o		2. Dete of Deeth Month Novembe		7 4:35pm
Examin	er	DOCTORS HOSPITA		100		4b. City, Town, or Le	ocation of Deeth	4c. County of De	GEORGE'S
Funeral Director		5. Sociel Security Number 6. S 5.77 32 0330 1 5.79 6.4 032 Usuel Residence of Decedent	ex	ge (In yrs. lest b	oirthday) if Under 1 Yee Yrs. Months Dey	s Hours Min.	8. Dete of Birth (Month, Dey,)	(ear) 9. E	Birthplece (Stete or Foreign Country) WARK, N.J.
death with the Maryland	octor	D.C.			wn or Location HINGTON				10d. Inside City Limits 1 Yes 2 □ No
23a or 2	al Dire	10e. Street end Number 1897 ALABAMA AVE.	S.E.		10f. Zip Code	0020		D. Citizen of Whete	
el', or items Examiner m	by Fur	11. Maritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorcad	12. Wes Decedent Armed Forces' 1 Yes 2 If Yes, Give Yeer or Dates:			f Hispenic Origin? (Sp uben, Mexican, Puerto			merican Indien, hite, etc.
than "natur he Medical	Completed	15. Decedent's Ed (Specify only highest gre Elementery/Secondary (0-12)	lucation de completed) College (1-4or	5+)	e. Decedent's Usuei Occ (Give kInd of work don tife. DO NOT use reti	upation e during most of work red)	ing	PRIVATE	ss/Industry
is marked other aumatic event, tr	To Be Co	17. Fether's Neme (First, Middle, Last) GEORGE W. WILLI		,,;	HOMEMAKER		e (First, Middle, Me	aiden Sumeme)	
If item 27 is marke or other traumatic		19e. informent's Neme/Reletionship (ICLARENCE M. SPRIG			b. Meiling Address (Stre B97 ALABAMA), Zip Code)
Department of Health e Important: If Item 27 is any Injury or other tra once.		20e. Method of Disposition 1 Mag Buriel 2 Cremetion 3 Cl 4 Donetion 5 Other (Specify		camete	of Disposition (Name of ery, cremetory or other p LINCOLN CEN			Dc. Location - City	
Importa any Inju once.		21. Signeture of Funeral Service Licen	Savare	71085	5538 MARLE	ANDER S. I	FORESTVIL	LE MD. 2	0747
/slcian ledical aminer		23a. Pert1. Enter the disease, or compshock, or heart feilure. List only of Immediate Cause (Finel disease or condition resulting in deeth)	e.	ep.	consequenca of):			,	Approximate interval Between Onset end Deeth
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ysicia ne bur	ca	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last	b		consequence of):				
ittending physicia for use es the bur	Physician/Medical	triet initieted events	c	Due to (or es e	consequenca of):	given in Pert I.		/	ute to the cause of death'
igned by the attending physicia be deteched for use as the bur	by Physician/Medical	resulting In deeth) Last	cd	Due to (or es e	consequenca of):	given in Pert i.		2 No 3□	Probably 4 Unknow
ate has been signed by the attending physicia page 2 should be deteched for use es the bur	Completed by Physician/Medical	resulting in deeth) Last Part ii. Other eignificant conditione co	cd	Due to (or es e	consequenca of):	given in Pert i.	1 ☐ Yee	eutopsy 24t	Probably 4 Unknow
certificate has been signed by the attending physicia rector, page 2 should be deteched for use es the bur	Be Completed by Physician/Medical	Part ii. Other eignificant conditione co	Mosnital	Due to (or es e	consequenca of): In the underlying cause of	26. Placa of Deet	1 Yee 24e. Wes en performe 1 Yes	eutopsy 24k	D. Were eutopsy findings aveileble prior to completion of cause of deeth? 1 Yes 2 No
inysician: The lew requires that the death certificate be his certificate has been signed by the attending physicia al director, page 2 should be deteched for use as the bur	To Be Completed by Physician/Medical	Part ii. Other eignificant conditione co	Hospitel: Inpatie 28e. Dete of Inju (Month, De	Due to (or es e ut not resulting ent 2 = ER/O ry y Year) 28b.	consequenca of): In the underlying cause of the under	26. Placa of Deetl other: 4 \(\text{Nursing Ho} \) ury et ork? \(\text{Yes} \) 2 \(\text{No} \)	1 Yee 24e. Wes en performe 1 Yes 1 Yes 1 (Check only one) me 5 Resident 28d. Describe how	eutopsy 24t 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 No	D. Were eutopsy findings aveileble prior to completion of cause of deeth? 1 Yes 2 No

29c. License number 29d. Dete signed (*Month*, *Dey*, *Year*) 11/9/97 ≥ 29b. Signeture and title of cartifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

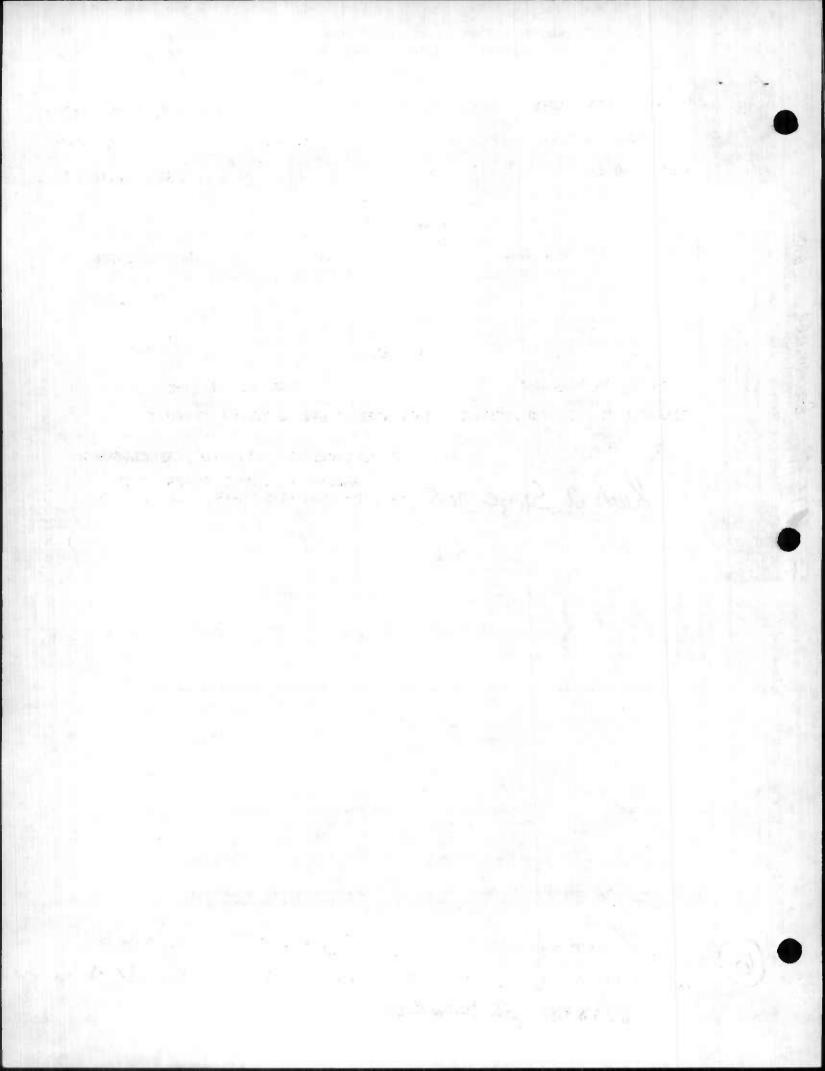
SANT IN 500 Suite 102 3060 Mithell willer Rd Brune My

31. Date filed (Month, Day, Year)

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State Registrar

NOV 13 1997

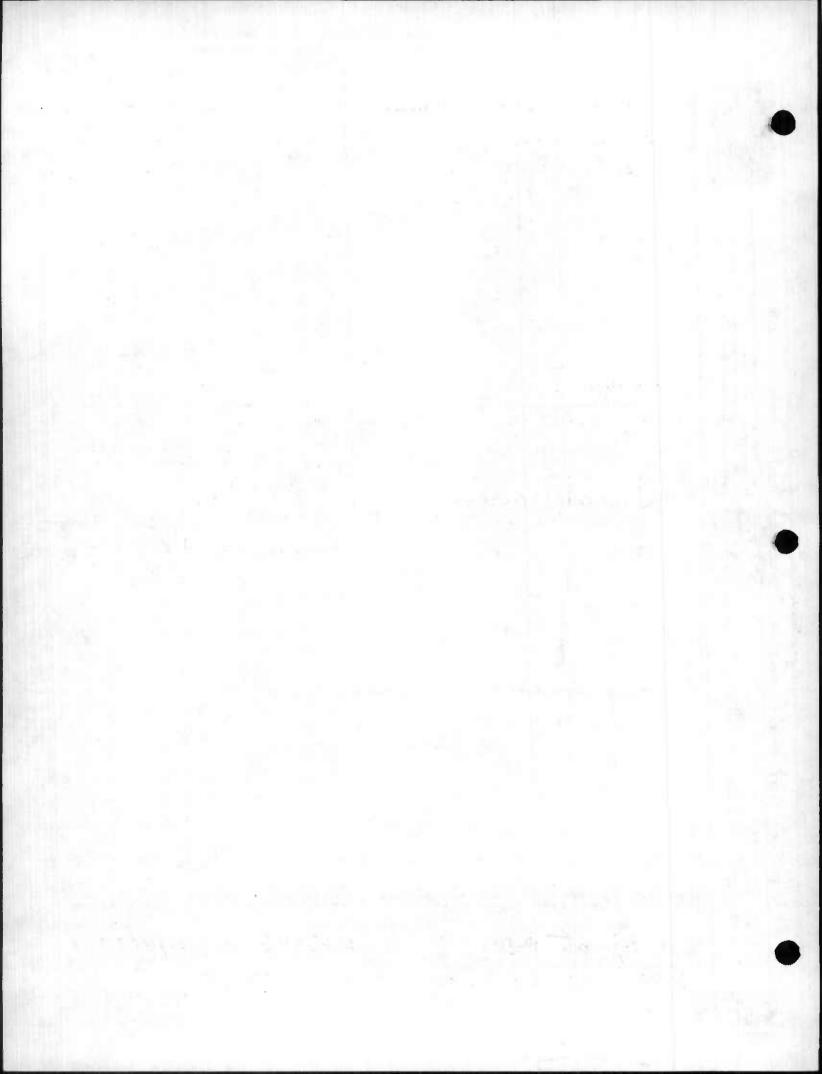


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle I ast) 2. Date of Death 3. Time of the Month **Physician** Elizabeth Albin Thornhill November 4, 1997 12:05 A.M. /Medical 4a. Fecllity Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14312 Mount Oak Road Prince George's Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. July 30, 1926 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 XF Yrs 71 Director 196-16-7665 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 X Yes 2 ☐ No Virginia Page County Directo Stanley 10e. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code 239 Thornhill Road 22851 of America Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Status filed within 72 hours efter Hygiene. 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ₩ Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumetic avant Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gorman Pierce Elizabeth Carter 0 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne P. Thornhill / Son 14312 Mount Oak Road, Mitchellville, Maryland 20721 20b. Placa of Disposition (Neme of cometery, crematory or other place)
Indiantown Gap
National Cemetery 20c. Location - City or Town, Stete Indiantown Gap, 20a. Method of Disposition Dete W Burlal 2 ☐ Cremation 3 ☐ Removal from State November 4 ☐ Donetion 5 ☐ Other (Specify) 6, 1997 Pennsylvania 21. Signature of Funeral Service Licensee M00690 22. Name and Address of Facility
The Bradley Funeral Home Couser 187 East Main Street, Luray, Virginia 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Deeth **Physician** 4 MONTHS /Medical Immediate Cause (Finel RENAL CELL CARCINOMA disease or condition resulting in death) Examiner Examiner burial-transit be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last and Due to (or as a consequence of) Box 68760 physician Physician/Medical the Due to (or as a consequenca of): 98 usa P.O. signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? should 24a. Was en eutopsy performed? Completed page 2 s 1 ☐ Yes 2X No certificate 1 Tyes 2 No Division of Vital Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖔 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 ☐ Pending death. 1 Yes 2 No Investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) within 24 hours after d To the Funeral Direct completaly filled in by 4 D Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) ŝ 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D43346 30 Name and addings of person who completed cause of death (Item 23a) (Type, Print) CLINTON MD 20735 26 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 05 Daydson Registrar

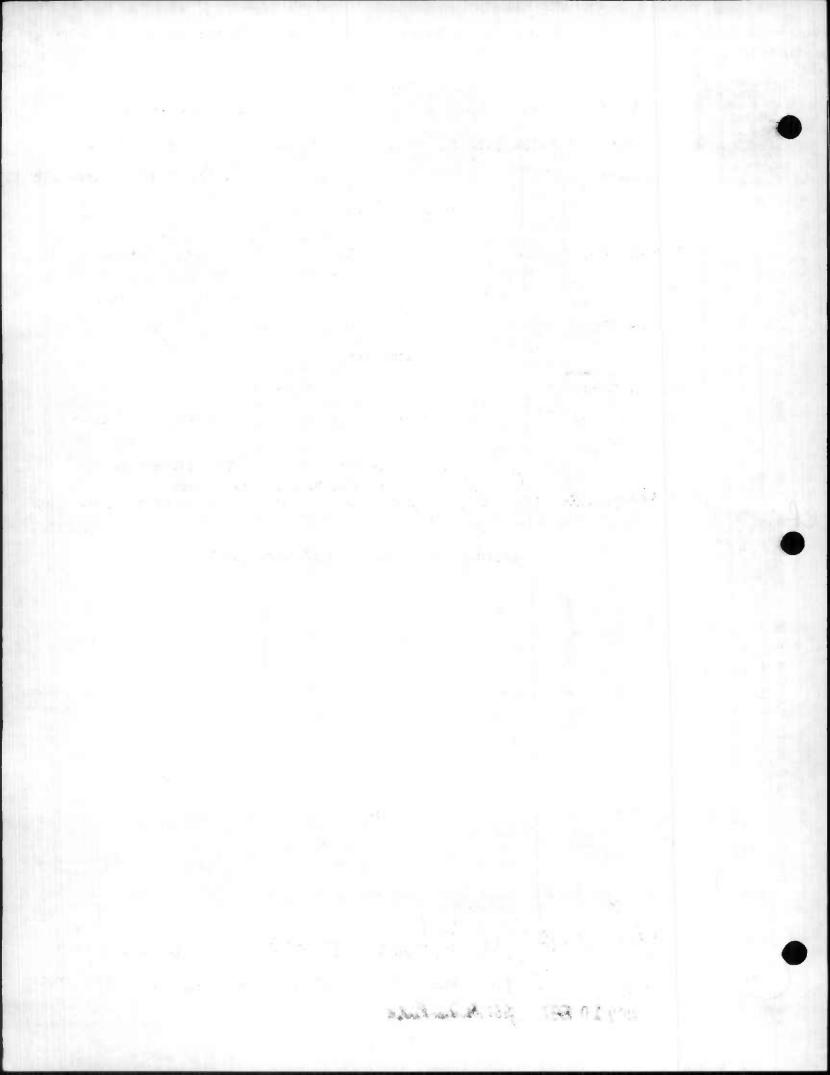


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey NOVEMBER 03 1997 01:31 PM **Physician** NELSON GARY THOMAS /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PRINCE GEORGES HEALTH BOWIE CENTER BOWIE If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1∑M 2□ F 12 **Vrs** Director 579-11-5061 Oct 22, 1985 Washington, DC Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examinar must be notified at 10d. Inside City Limits Washington, DC Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1319 Columbia Road NW 20009 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural", or ite, any injury or other traumatic event, the Moster Exempted. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) NONE NONE Unemployed 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Gary N. Thomas. Sr Sandra A. Long 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Mother Sandra A. Long 1319 Columbia Road NW, Washington, DC 20009 20e. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 11/5/97 Alexandria, VA 22. Name and Address of Facility Alexander S. Pope Funeral Home 21. Signature of Funeral Service Licenses 23a. Perfl. Enter the disease, or complications that caused the deeth. So not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. 2617 Pennsylvania Ave, SE, Washington, DC 20020 Approximate Intervel Between Onset and Death **Physiclan** /Medical Immediate Ceuse (Finei disease or condition resulting In death) SEIZURE DISORDER & CRREBRAL PALSY Examiner Due to (or es a consequenca of): Examiner physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting In deeth) Lest Due to (or es e consequença of) Box 68760. Physician/Medical Due to (or es e consequence of) attending Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. P.O. the 23b. Did tobacco use contributs to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. py 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes an autopay performed? Completed peed page 2 hes certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) iner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 30 DOA After this funeral 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28e. Dete of Injury (Month, Day Year) 5 Pending Neturel 1 ☐ Yes 2 ☐ No Hospital or Attendi n.24 hours efter death. Funeral Director: A death. investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Pieca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end pieca, end que to the ceuse(s) and mainle. So stated.

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State Registrar 31. Dete filed (Month, Day, Year) NOV 10 1997



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month **Physician** 6, 1997 NATHANIEL TALLEY November 11:00AM /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, give street end number) 4c. County of Deeth Examiner 11624 Stuart Lane, #104 Silver Spring Montgomery If Under 1 Yaar If Under 24 Hrs.
Months Deys Hours Min. 6. Sex 1X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpleca (Steta or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funerai** Deys Yrs. Director 432-30-4891 April 20,1926 Arkansas Usual Rasidence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or Items 23s or 25s-f show traumatic event, the Medical Examiner must be notified at Montgomery Silver Spring MD 1√ Yes 2 No Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 11624 Stuart Lane, #104 20904 U.S.A. Funeral 12. Wes Decedent Evar In U,S. Armed Forces? 1≦ Yas 2 □ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after Hygiene. 1 ☐ Navar Merried 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 □ Divorced permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural, any injury or other traumatic event Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedeni's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 2 yrs. Chef Nursing Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be Tom Donahue Annie Mae Emery 2 19a. Intorment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Denise Talley - Daughter 14224 Alderton Road, Silver Spring, MD 20906 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) 11-10-97 Silver Spring, MD Gate of Heaven Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Marshall's Funeral Home, Inc. 4217 9th Street N W Washington, DC 20011 Approximately or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel 4 MONTHS e METASTATIC COLON CANCER disease or condition resulting in deeth) **Examiner** Due to (or es e consequence ot): Examiner requires thet the death certificate be axecuted buriel-trensit Sequantially list conditions, if any, leading to immadieta ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest pue Due to (or es e consequence ot): physician e P.O. Box 68760. Physician/Medical Dua to (or as a consequence ot): attending g signed by the at id be detached for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, þ cate has been sig 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? The lew r certificate has 1 ☐ Yes Ž□ No 1 Yes 2 No Division of Vital Attending Physician: Be 25. Wes cese reterred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa Rasidence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 Yes 2 No After this funeral 27. Manner ot Deeth 28e. Dete ot Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation Netural To the Hospital or Attendin Wilner 24 hours after death. To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident In by the 6 Could not ba determined 3 Suicida 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 28a. Plece of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner: On the basis of examiner: On the basis of examiner: On the basis of examiner end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. Medical 29a, Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature agd title of certifier 29c. License number Muem # 1 9, 1997 D31563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles M. Benner, M.D., 11251 Lockwood Drive, Silver Spring, MD 20901 31. Dete tiled (Month, Day, Year) NOV 1: 0 1997 32. Aggistrar's Signeture State

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State of Maryland / Department of Health and Mental Hygiene 7

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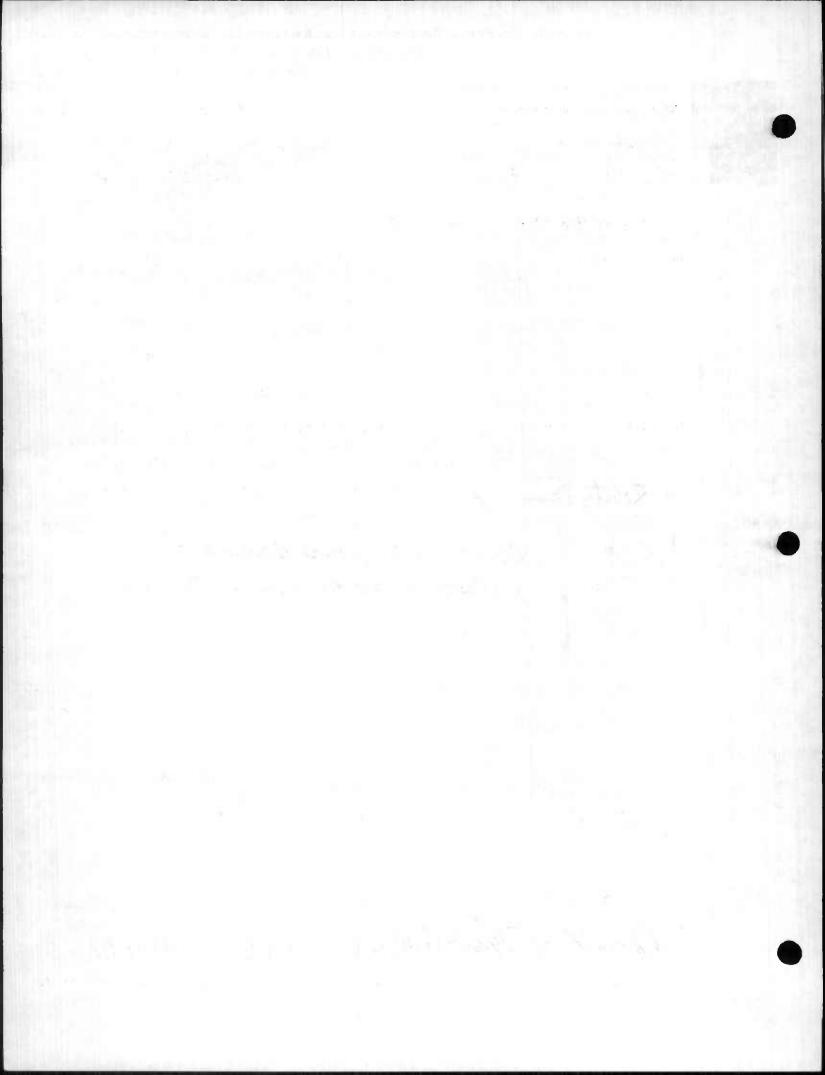
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Baltimore,	penimic rages i and 2 should be lied within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ma ODGs.		1 ☐ Burial 2 □ Cremetion 3 4 □ Donation 5 □ Othar (Spec		camatai	ry, cram	atory or other pl	etery 11				Maryland
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	hysician /Medical xaminer	er	Immediata Causa (Finel diseasa or condition rasulting in death)	a. Con	gestive bua to (or as a	consequ	Heard	t Faile	ne		1	Onsat and Death
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State of Maryland / Department of Health and Mental Hygiene

		1 December 1 Nove /First Added La			Cer	tificate o	f Death		Reg. No.	1 3	583	6
Physicia		1. Decedent's Name (First, Middle, La Naomi Louise Wel						2. Dete of De Month Novemb	Day	Year 1997	3. Time of De 4:30p	
/Medica		4e. Facility Neme (If not institution, giv		r)			4b. City, Town, or				4:300	2111
Funeral Director		26 Sunset Drive 5. Social Security Number 6. S 214-74-0747	ex 7. A	ge (In yrs. I	est birthday) 3 Yrs.	If Under 1 Yes		B. Date of Bir	th ey, Year)	9. Birthple Count Mary	ace (Stete or F	oreig
ž		Usual Residence of Decedent 10e. Stete 10b. County		10c. City	, Town or Loc	cation					d. Inside City I	Limit
Fied a	tor	Maryland Anne Aru	ndel		erna Pa					1.0	1 Yes 2	
or 28	Director	10e. Street and Number				10f. Zlp Code	•		10g. Citizen of	Whet Count	ry?	Λ
	Funeral I	26 Sunset Drive 11. Marital Status	12. Was Deceden Armed Forces	?	S. 13. V	211 Vas Decedent o Yes, specify Co	46 f Hispanic Origin? (S uban, Mexican, Puer	Specify Yes or No to Rican, etc.)	USA 14. Rad Bla	ce - America		
l', or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2.K If Yes, Give Yeer or Dates		1	□Yes 2√□N	lo Specify:		Specifi	white		
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PEE	10	John Burkert 19a. Informent's Neme/Relationship (1)	Type, Print)		19b. Mailin	g Address (Stre	Mary Agr			Stete, Zip	Code)	
4 4 2		Mr. L. Earl Weller	neyer		26 St	unset Di	rive, Seve	erna Par	k. MD 2	1146		
5 2 0		20a. Method of Disposition 1 → Burial 2 → Cremation 3 →	Removal from State	20b. PI	ace of Dispos metery, crem	ition (Neme of etory or other p	elece)	Date	20c. Location		m, Stete	
트론증		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Par		Cemeter		7, 1997	Baltime	ore, N	1D	
any ir		23a. Pert1. Enter the disease, or comphock, or heart failure. List only	-/	r	Ba 49	arranco 95 Ritch	and Sons,	Severna	Park. 1	Home MD 211	46	
g physicia as the bur	an/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underfyling Cause (Disease or Injury that initiated events resulting in deeth) Last	a. Cerson. b. Arl c.	Due to (or	as a consequence of a c	uenca of):	a Ac	cedor s	DIFACE	u		
the att	Physician/N	Part II. Other significant conditions co	ontributing to death	but not resu	Iting In the un	derlying cause	given in Pert I.	23b. Dld	tobacco uae co	ntribute to	the cause of d	iea
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pege 2	Com							10	Yes 2No	1 🗆	Yes 2□ No	•
ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Whor	ath (Check only o				
ter this neral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inj (Month, D	ury	ER/Outpatient 28b. Time of Injury	28c. In	4 Li Nuising r	fome 5 Resi	dence 6 Oth			
I Director: Af	Certification:	3 Suicide 6 Could not be determined	28e. Piece of Ir	jury - At hor	me, farm, stre	et, factory, offic	е	28f. Location (City or To	Street end Numb wn, Stete)	per or Rural	Route Number	r.
Funera	edical	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Example 2 Medical Example 2	Iner: On the basis of and manner s	of examineti	rledge, death on end/or inve	occurred at the estigation, in my	time, dete end plece opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date end plece,	anner as sta and due to	ited. the ceuse(s)	
within 24 hours ener To the Funeral Dire completely filled in b	Me	29b. Signature and title of certifier	y. M.	elf)	Pins	29c. Lice	nse number	3	29d. Date signe	d (Month, D	Yey, Yeer)	
		30. Name and address of person who of Dona D H. Is	completed cause of	death (Item			ON RP.	SEVERN	A PARK	M	0 2114	16
State	е	31. Date filed (Month, Dey, Yeer)	32. Regist	m O,	ure	KOBINS	EDU RP,	SEVERN	A YARK	M	U X1	114



State of Maryland / Department of Health and Mental Hygiene 97 35837

				Cer	tificate of	Death		R	eg. No.		000	•
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hysician /Medical	Dot	rothy N	Wil	.de				October		1997	4:20	PM
Examiner	4e. Fecility Neme (If not Institution	on, give street end n	um <i>ber)</i>			4b. City, To	wn, or Lo	cation of Deeth	4c. Count	y of Death		
	906 Severn	Avenue				Edge	wate	er	Ann	e Aru	ndel	
ıneral	5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthdey)	If Under 1 Yeer Months Deys	If Under Hours	24 Hrs. Min.	8. Dete of Birth (Month, Dey	Veer	9. Birthp	lece (Stete or try)	Foreign
rector	216-44-5007	1□M 201F	75	Yrs.	months boys	Tiodis	14101.	Dec 29	1921	Mar	yland	
	Usuel Residence of Decedent											
r than "natural", or flams 23a or 28a-f show the Medical Examinet must be notified at completed by Funeral Director	10a. Stete 10b. Count	У	10c. City, Tow	n or Loc	cation					1	0d. Inside City	
ct e	MD Anne	e Arundel	An	napo	olis						1XX es	2 No
be notified Director	10e. Street end Number				10f. Zip Code			1	0g. Citizen of	Whet Coun	try?	
1 E	985 Awald Re	oad			2.	1403			United	Stat	es	
Funeral	11. Meritel Status	12. Wes Dec	cedent Ever in U,S.	13. W	Ves Decedent of H Yes, specify Cube	lispenic Orig	gin? (Spe	ecify Yes or No-		ce - Americ		
是 正	1 Never Married 2 Ma		2 X X 0		☐ Yes 2XXNo	Specify:	, , aonto i	inoun, oro.,			NG.	
l by	3 Vidowed 4 □ Divorce	d Yeer or I	Detes:		LI 165 ZALMIO	Specify.			Specif	Whi	te	
Completed	15. Decede	nt's Education	16e	Decede	ent's Usuel Occup	etion	of worki	na	16b. Kind of B	usiness/inc	lustry	
ğ	Elementery/Secondary (0-12)		(1-4or 5+)		kind of work done O NOT use retired		or works					
Ö	7			Cafe	eteria Wo	orker			Fo	od		
Be	17. Fether's Neme (First, Middle	, Last)				18. Mothe	r's Name	(First, Middle,	Meiden Sumar	ne)		
2	Frank Stokes	3				N	larga	ret Fre	eman			
	19a. Intormant's Neme/Relation	ship (Type, Print)	198	o. Meiling	g Address (Street	end Numbe	or Aure	I Route Number	, City or Town	, Stete, Zip	Code)	
	George R. Wild	de (Son)		906	Severn A	Avenue	e Ed	gewater	, Mary	land	21037	
	20e. Method of Disposition		20b. Plece o	of Dispos	ition (Neme of etory or other plea	ce) Oat	28 1	Date QQ 7	20c. Location	- City or To	wn, Stete	
	Burial 2 Cremetlon		State Hillor	oct	Memorial	Come	20 1		Annono	lie	Man. 1 a	- d
once. To Be C	21. Squeture of Funerel Service		HIGHTEL	22.	Name end Addre	ss of Fecilit	v- 1		Annapo	118,	Maryla	na -
Suppose (1000	14	1	1.	Name end Addre	5 01	'John	M. Tay	lor Fu	neral	Home,	Inc.
	23a. Pert1. Enler the diseese, of	V. Juy	anused the death. De		7 Duke o					olis,		
	shock, or heart feilure. Lis	t only one ceus, on	eech line.	not ente	r the mode of dylr	ig, such es	cardiec o	r respiretory err	est,	1	Approximete Intervel Betw Onset and De	reen
an al	Immediate Course (Final									1	Oriset and Di	90111
ner	Immediete Ceuse (Finel diseese or condition resulting In deeth)	Θ	1/8/2018	7507	14 /m	run				1		
- I			Due to (or es a	consequ	uerice ot):					1		
Examiner		b . 4	une C	no	can)							
/Medical Examir	Sequentielly list conditions, if eny, leeding to immediate		Due to (or es e	consequ	ience of):							
	Cause (Diseese or Injury	c										
edical	thet initiated events resulting in deeth) Lest		Due to (or es e	consequ	ence ot):							
Me		d								į		
lan												
ls/	Pert II. Other significant condition	ons contributing to d	leath but not resulting i	n the un	derlying cause giv	en in Pert I.		23b. Did to	bacco use co	ntributa to	the cause of	f death?
Physician	(10)	PI						1694	as 2 No	3 Prot	ably 4 L	Jnknown
þ							- 10					
								24e. Wes a		24b. We	ere autopsy tir eliable prior to	ndings
Completed								porton		COL	npletion of ca death?	
E								1 🗆 Y	as sha No		Yes 2□ N	No.
	25. Wes case reterred to medical	al				OF Diago	of Door	(Check only or	AA		, . 60 ZUI	
o Be	exeminer?	Hospital:	Inpatient 2 ER/O	itasticat	3 DOA Oth				-	nor /6"	1 C - 1	77-
cation: To Be Com	27. Menper of Deeth	28e. Dete	of Injury 28b.	Itpatient	3LI DON	4 LINU		ne 5 Reside			Son's	Home
tion	1 Naturel 5 ☐ Pendi		nth, Day Year)	Injury	28c. Injur Wor	k? Yes 2 □ !			,ary orout			
Certification:	3 ☐ Suicide 6 ☐ Could	not be	e ot tnjury - At home, fa	rm stro				28t. Location (S	reet end Numi	her or Rura	Route Numb	oer
P. T.	4 ☐ Homicide determination	nined 200. Flack	ing, etc. (Specify)	, энө	or, rectory, onice		-	City or Town	n, State)	J. J. HUIB	. Toule Hunte	,
	29a. Certifier 1 Certifyi	na Physiology To #	haet at my large to	doot	nonuero d at the co		d al	and due to the			et e d	
edicai	(Check only one)	Examinar: On the b	e best ot my knowledge easis ot examinetion en	d/or inve	occurred at the tine estigetion, in my o	ne, dete end pinion, deat	n piace, e	end due to the c ed at the time, d	euse(s) end m ete end plece,	enner es st end due to	ated. the ceuse(s)	
Medical Certifi			ner steted.		200 Linera	a number			Od Data alar	d /Marth	Day Vari	
	29b. Signature end title of certific	1			29c. Licens D235	111111111111111111111111111111111111111		2	9d. Dete signe			
	7	7)			D233				Octobe	Er 2/,	1997	
	30. Name and eddress of persor											-
	Anthony M. Ca	puto, M.D	. 139 Old	Solo	mons Isl	and R	oad	Annapol	is, MD			
State	31. Date tiled (Month, Day, Year		Registrer's Signeture	٠ س	1.00							
egistrar	NOV 03	1997	agustrer signeture	-Mand	العالم							

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State of Maryland / Department of Health and Mental Hygiene O

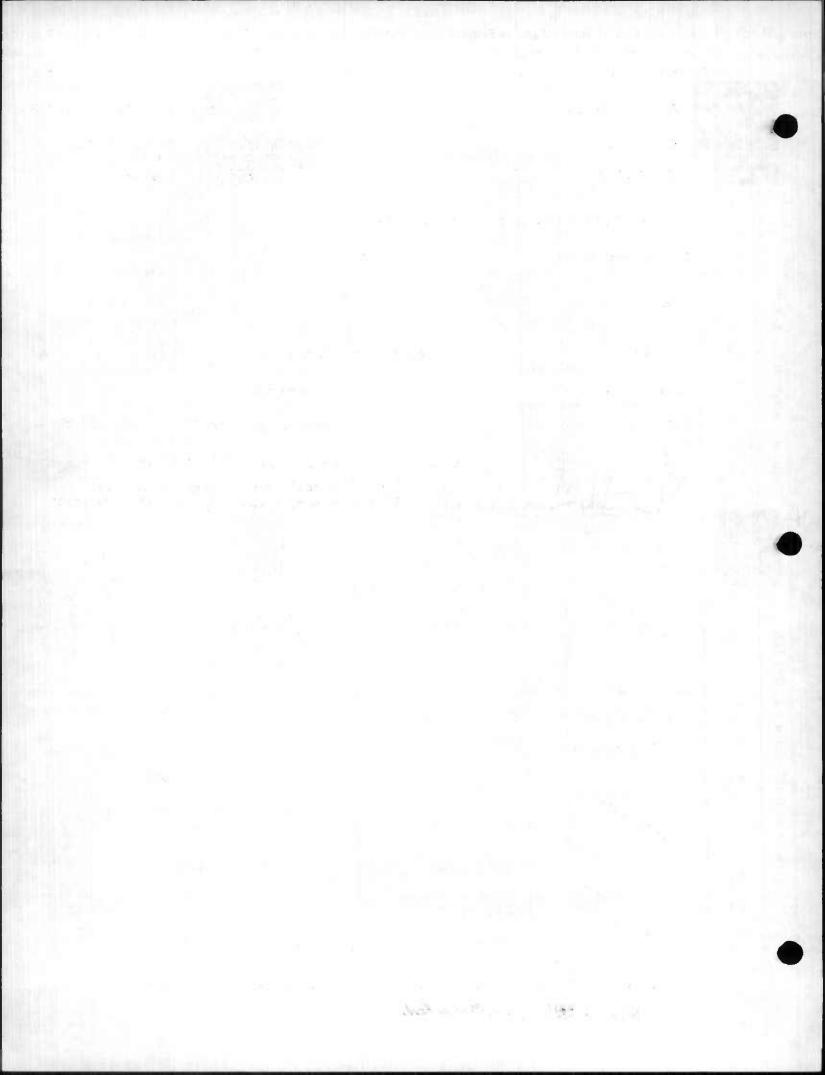
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Data of Death 3. Time of Death **Physician** NEN6 949 /Medical 4a. Facility Nama (If not institution. give street and number 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner lorth truvde olen Survie If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1 ☐ M 2 🖫 F 77 Yrs. Director 102-64-3113 28 1920 CHINA Usual Residence of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits ns 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 CHINA Funeral filed within 72 hours efter death 520 STEWART AVENUE items ? 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Was Dacedant of Hispenic Origin? (Spacify Yas or No If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - Amaricen Indian, Bieck, White, etc. "natural", or item 1 Navar Married 2 Marriad 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: CHINESE 3♥ Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) Hygiene. Eiementary/Secondery (0-12) Coitaga (1-4or 5+) N/A HOMEMAKER OWN HOME Baltimore, Maryland 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be in nent of Health and Mental I (UNKNOWN) (UNKNOWN) (UNKNOWN) (UNKNOWN) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Ralationship (Type, Print) 60 Health 8 HAN BO HE (SON IN-LAW) 520 STEWART AVENUE, GLEN BURNIE, MD. 21061 or other t 20a. Method of Disposition 20b. Piaca of Disposition (Nama of camatary, crematory or other placa) Date 20c. Location - City or Town, Stata 1 Buriai 2 □ Cramation 3 □ Removal from Stata Depertment if important: if any injury or 4 ☐ Donation 5 ☐ Othar (Spacify) GLEN HAVEN MEMORIAL PARK 11/3/97 GLEN BURNIE, MD. 21. Signatura of Funeral Service Licensee 22. Nama end Addrass of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 1.00 all 23a. Part1. Enter the disease, or complications that course the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Interiosclerotic Heart Disease /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, laeding to immadiate ceusa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) P.O. Box 68760, Physician/Medical the Due to (or as a consequence of): use Pert ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? rate has been signed by pege 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown Records, g 24b. Wera sutopsy findings available prior to complation of causa of death? Be Completed 24a. Was an autopsy certificate has 251 No 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: director, 25. Was cesa rafarrad to medical 26. Placa of Death (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ■ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mannar of Deeth 28a. Date of Injury (Month, Day Yaar) 28b. Tima of 28d. Dascribe how Injury occurred 28c. injury at Work? After 5 Panding invastigation Naturai 1 ☐ Yas 2 ☐ No death. 2 Accidant after death 6 Could not be datermined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Spacify) Location (Street and Number or Rurel Routa Number, City or Town, Stata) illed in by 4 Homicida 24 hours e 29a. Cartifian 1 🖵 certifying Physician: To the best of my knowladga, daath occurrad at tha time, date and piace, and due to tha ceusa(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and menner steted. To the within 2 To the Deputy 29c. Licansa number 29b. Signature and title of certifiar 29d. Data signed (Month, Day, Year) se of death (ttam 23a) (Type, Print) ones 32. Registrar's Signatura 31. Data filed (Month, Day, Year) Mandale State 0 4 1997

Registrar

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State of Maryland / Department of Health and Mental Hygiene 97 358

					Certificate of	Dealli	Reg	. No.	35839
Dhugish		1. Decedent's Name (First, Middle, La	nst)				2. Date of Deeth Month	Day	3. Time of Deat
Physicia: /Medica	_	Elsie Wurzbac	her				November		997 2:05 p
Examine	er	4a. Facility Neme (If not institution, given	ve street and number)			4b. City, Town, or L	ocation of Death	4c. County	ot Death
Funeral	-		Sex · 7. Age	e (In yrs. lasi	t birthday) If Under 1 Yea Months Day			- T	9. Birthplace (State or Fore
Director		Usual Residence of Decedent	1□M 2₺ F	98	Yrs.	TIOUTS IVIII.	Mar. 27,		Germany
how		10a. State 10b. County		10c. City, T	Town or Location				10d. Inside City Lim
T S	cto	Maryland Prince G	eorge's	New (Carrollton				1 1 Yes 2 □
ms 23s or 28s-f show	ai Director	10e. Street and Number 6120 Lamont Drive			10f. Zip Code 20784			S.A.	/hat Country?
al', or its	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 M N If Yes, Give Year or Dates:		13. Was Decedent of It Yes, specify Cu		ecify Yes or No- Rican, etc.)	Blac	a - American Indian, k, White, etc. White
natu Seal	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	1	16a. Decedent's Usual Occ	upation	ing 16	b. Kind of Bu	siness/industry
	Completed	Elementery/Secondery (0-12)	Coilege (1-4or 5	5+)	(Give kind of work don life. DO NOT use reti	ed)	9		
Part the	Ö	12		5	Seamstress /	Homemaker		lothin	0
end Mental Hygiene. s marked other than aumatic event, the H	Be	17. Father's Name (First, Middle, Last				18. Mother's Nam	e (First, Middle, Ma	iden Sumem	Θ)
marked umatic		Ernst Schauerhamm				Emma We	tzel		
end sim man		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street	et end Number or Rui	al Route Number, (City or Town,	State, Zip Code)
Health em 27 rther tr		Norma Cobb - Daug	hter		6120 Lamont	Drive, Ne	w Carroll	ton, M	laryland 2078
10 1		20a. Method ot Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cem	e of Disposition (Name of etery, crematory or other part Hill Cemet				City or Town, State d, Maryland
Depertment Important: I any Injury o once.		21/Signature of Fundral Service Liber	nsee	1	22. Name end Add				
		thanky t	rearriel	rily	4739 Balt	imore Ave	nue, Hyat	tsvill	e, MD 20781
		23a. Part1. Enter the ditease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	not enter the mode of d	ring, such es cardiac	or respiratory arres	t,	Approximate Interval Between
ysician	1	7	0	N					Onset and Death
Medical		Immediate Cause (Finel	/ / 0			1			
		disease or condition	· (ax	olia	c axxx	725			11.11.9-
caminer		resulting In death)	· Care	Olia Due to (or as	a consequence of):	est			11.11.97
	ner	disease or condition resulting in death)	Corp	Due to (or as	s a consequence of):	25+			11:11.9-
	aminer	resulting in death)	b. Q89	494	s a consequence of): Long a s a consequence, of):	est.			11.11.9-
ing physician and e es the burial-transit	Medic	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c. Congi	Due to for as	hmia	st-fail	488		11:11.9 -
ing physician and e es the burial-transit	Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c. Congi	Due to (or as	s a consequence of):	St-Jail	48 e	acco uss con	aprox 24 aprox 24 atribute to the cause of des
by the ettending physician and eched for use as the burial-transit	Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Part II. Other significant conditions of the condition	b. Congi	Due to (or as	s a consequence of):	St-fail	23b. Did tobi		Gprop 29 Gritibute to the cause of dea 3 Probably 4 Unkn
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rectificate has been signed by the ettending physician and rector, page 2 should be deteched for use as the burial-transit	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inhitated events resulting in deeth) Lest Part II. Other significant conditions of the condition	b. Congression of the contributing to death but of 5.	Due to (or as	s a consequence of):	26. Place of Deet	1 Vee	autopsy d?	3 Probably 4 Unkr 24b. Were autopsy findinavallable prior to completion of cause of death? 1 Yes 2 No
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in 24 hours effer deeth. Ne Funeral Director: After this certificate has been signed by the ettending physician and plately filled in by the funeral director, page 2 should be deteched for use as the burial-transit parties of programment by Directors and parties are programment.	ledical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Part II. Other significant conditions or II. Other significant conditions or II. Other significant	b. Congrid. c. Congrid. d	Due to (or as Due to (or as Due to (or as ut not resultin Party Year) 28 ury - At home examinetion	s a consequence of): Solution of line	26. Place of Deet ther: 4 Nursing Ho ury et ork? Yes 2 No	1 Yes 24e. Was an performe 1 Yes h (Check only one) ome 5 Resident 28d. Describe how 28f. Location (Stre City or Town, and due to the cau	autopsy sd? 2 DNo ce 6 Other injury occurrence and Number State) se(s) and means and place, e	3 Probably 4 Unkn 24b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No or (Specify) ed
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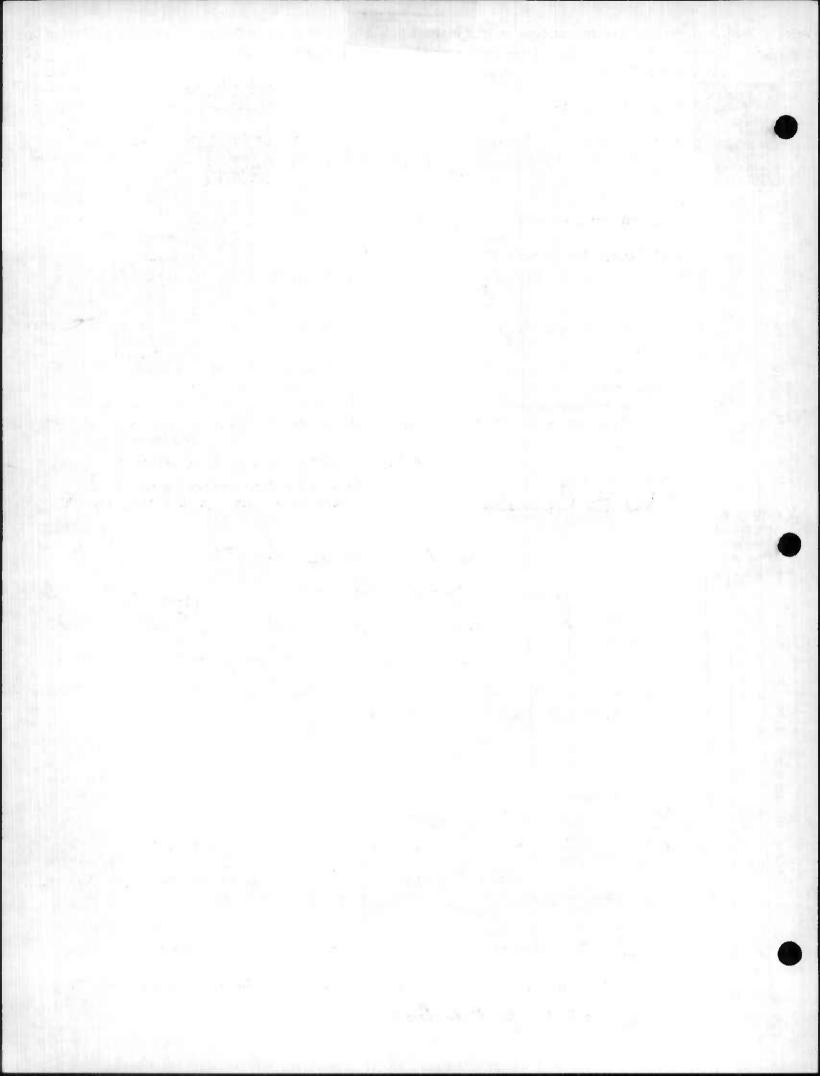
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month November 6, 1997 **Physician** Julia D. Wargo 8:30 pm /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1□M 2\F Months Days 229-03-6471 77 Yrs Director Jan. 16, 1920 Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov traumatic event, the Medical Examiner must be notified at 1 Ves 2 □ No Director Maryland Prince George's College Park 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? items 23s or 4711 Berwyn House Road #207 20740 U.S.A. Funeral Pagas 1 and 2 should be filed within 72 hours after death 12. Wes Decedent Ever In U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 🖺 No by Specify: White 3 ☐ Widowed 4 🎇 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry than Elementary/Secondery (0-12) 12 College (1-4or 5+) Hygiane. Cashier A & P Food Stores marked other permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Joseph Duncan Brooksie Lee Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stele, Zip Code) Janice A. Pelan - Daughter 13062-B Shadyside Lane, Germantown, Maryland 20874 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/11/97 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. **Physician** /Medicai Immediate Cause (Finel disease or condition resulting in death) Cardiopulmonou Examiner 3 D=70 The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Division of Vital Records, P.O. Box 68760. physician Due to (or as a consequence of): Physician/Medical scriptz Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t Il with fractured R+ Clavicle 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed Anemic 1 TYPS 2 NO 1 ☐ Yes 2 ☐ No certificata or Attending Physician: 25. Wes case referred to medical Be 28. Piece of Death (Check only one) examiner: 1 ☑ Yes 2 ☐ No Hospitel: 1⅓ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? After 5 Pending Investigation 1 Natural s after death.

I Director: Aft
of in by the fur Nov. 3, 1997 1 Yes 2 No 2 X Accident 11:00 \$ Subject Fell 6 Could not be 3 ☐ Sulcide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI completaly filled in At Home - Kitchen 4711 Berwyn House Rd, College Park, MD 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the cause(s) end manner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piaca, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D37934 November 12, 1997 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Trifoglio, M.D. 7500 Greenway Center Drive #430, Greenbelt, MD 20770 31. Date filed (Month, Day, Yeer) 32 Registrar's Signeture State Jaki Studier Rarball NOV 1 4 1997 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Leasth 9 Year **Physician** 1 Month 23:45 OWEN LEE WRIGHT /Medicai 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 4301 CANYONVIEW DRIVE | If Under 1 Yeer | If Under 24 Hrs. | 8, Dete of Birth | Months | Days | Hours | Min. | 8 (Month Cey, Yeer) UPPER MARLBORO P.G. COUNTY Birthplaca (State or Foreign N. Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1 X M 2 □ F 68 Yrs. Director 577-32-5115 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglena. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any follury or other traumatic event, the Medical Exprises must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD P.G. COUNTY UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 CANYONVIEW DRIVE 20772 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ∑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☐ No Specify: g 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) 2 College (1-4or 5+) Elamantary/Secondary (0-12) COMMISSARY MANAGER U.S.AIRFORCE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) JAMES WRIGHT MARCANA JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ROBERT L. ALLEN 4701 PLATA ST. CLINTON MD 20735 20b. Placa of Disposition (Name of cemetery, cremetory or other p 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Bunal 2 □ Cremation 3 □ Removal from State MD VETERAN CHELTENHAM 11-13-97 CHELTENHAM MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility 5538 MARLBORO PIKE FORESTVILLE MD 20747 Zung 11085 23a. Part Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Intarval Between Onset and Death Physician /Medical Immediate Cause (Final METASTATIC CARY WOMA OF APPENDIX YRS disease or condition resulting in daath) Examiner Examiner physician end s the buriel-transi Sequentially list conditions, if eny, leading to Immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 98 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 2 8 No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 8 Other (Specify) 2 No 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Placa of fnjury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Medical Examiner: On the bast of my knowladga, daath occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation. In my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) pletaly 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dev. Yeer) KEVIN J. MCKENNA, MAJ. USAF, MC MD-042348-L (PA) 11-10-97 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALCOLM GROW USAF MEDICAL GR, 1050 W. PERIMETER PD, ANDREWS AFB, MD 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Mi Midson Royall NOV 1 0 1997

Registrar

Baltimore, Maryland 21215-0020

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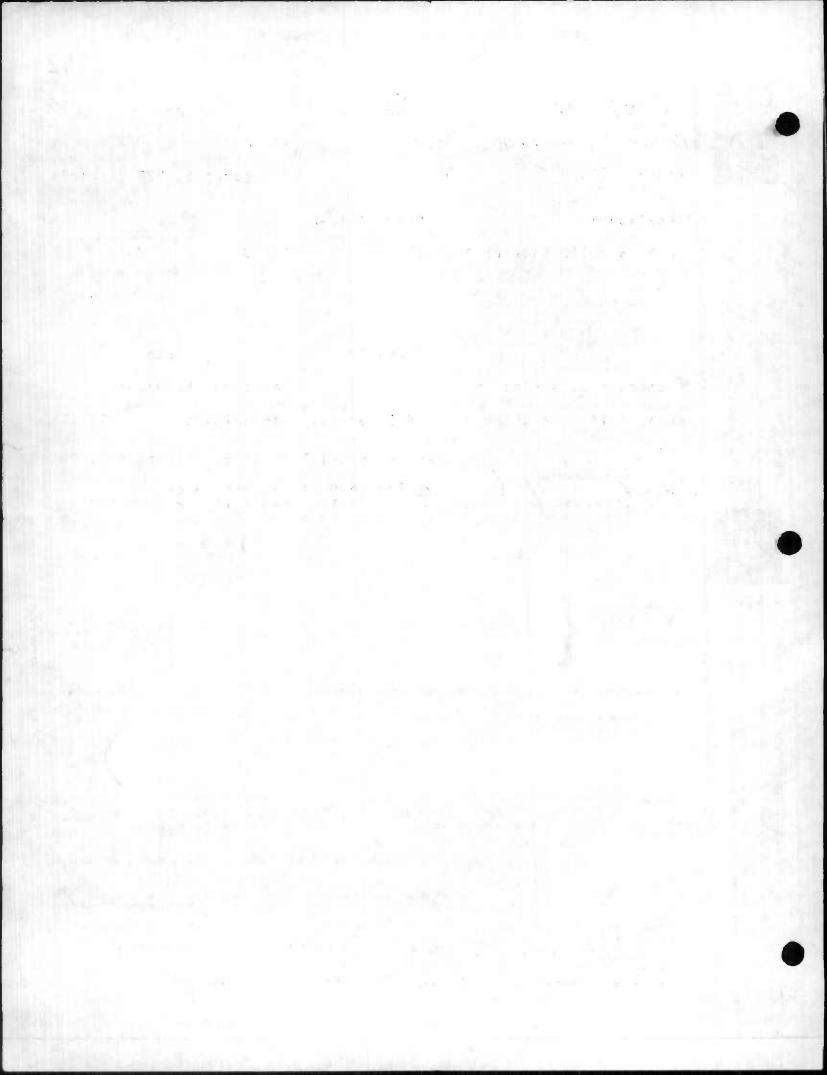
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State of Maryland / Department of Health and Mental Hygiene

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0		h with the	Funeral Director	10e. Street and Nu 3622 Fai		enue			10f. Zip Cod 212	216		10g. Cl	tizen ot Who	et Country	15		
Allen	aryland 21215-0020	within 72 hours efter death with the Meryland ilene. In then "natural", or items 23e or 28e-f ehow the Med cal Examiner inval be notified at	by Funer		ried 2 Married	Armed F	No Sive	,S.	13. Was Decedent of If Yes, specify C		(Specify Yes or N erto Rican, etc.)	0-	14. Rece- Bleck, Specify:	White, et	c.		
Bernae	9-0	2 hou			15. Decadent's	Education		16a. D	ecedent's Usuel Oc	cupetion		16b. K	and of Busin	ness/Indu	stry		
0	21	thin 7 e. an "n	Completed	Elementery/Sec	cify only highest gondery (0-12)		(1-4or 5+)	(1)	Give kind of work do life. DO NOT use re	ne during most of w tired)	rorking	Ba	ltimo	re C	hild		
	121		Son			4		Secr	retary					ive :	Services		
9	pug	be filed ntal Hygi od other event,	Be	17. Father's Name		st)					ame (First, Middle	e, Meider	Sumame)				
2	2	should and Men marke umaric	2	Moody Lu						Ada Je							
1	Ma	ges 1 and 2 should tt of Health end Men if Item 27 is merke or other treumatic		19a. Intormant's N Leveda A		(Type, Print)	daughter		Mailing Address <i>(Str</i> 22 Fairvie						ode)		
	ē,	of Health of Health if item 27 is or other tr		20a. Method of Dis	sposition		20b. F		Disposition (Name of crematory or other)		Dete	1	ocation - Ci		n, State		
	9	Pages nent of nt: If ite			☐ Cremation 3 5 ☐ Other (Spec		ii State		on Forest		Nov 24	Owi	nas M	ille	. Md		
	Baltimore,	permit. Pages Department of Important: If it any Injury or once.		21. Signature of F			n Gai	.1150	22. Name and Ad			1		-			
	m	e d i e	1	1/1	+ 9	1	Ery K.		2501 Gwar	nns Falls	Nutter PKWV Ra						
				23a Part I. Enter	the disease, or co	hplications thet	caused don't	h. Do no	t enter the mode of	dying, such as cardi	ac or respiratory	arrest,	OLO,		Approximate		
	ч	Physician		snock, or nea	art fallure. List on	y one cause on	each line							C	ntervel Between Onset end Death		
	-11	/Medicai		immediate Cause disease or conditi	on		1704	nsta	the Bre.	est Cu	runama			3	2 years		
	н	Examiner		resulting in death)		9			ensequenca of):						3		
		pel led	Examiner			b											
		ertificate be executed ling physician end se es the buriel-transit	Exan	Sequentielly list or if eny, leeding to in cause. Enter Und Cause (Disease or that initiated event	onditions, mmediate		Due to (c	r as a co	nsequenca ot):					Ì			
	68760,	Siciar B buri		Cause (Disease of their initiated event	erlying r injury s	c	Duo to /o		nsequenca of):					1			
	89	2 00	Medical	resulting in death)	Last		Due 10 (0	i es a coi	risequenca or).					1			
	Вох	eath certifi ettending for use es	an/N			d											
		he ett	Physician	Part II. Other signi	ficant conditions	contributing to	death but not res	ulting in t	he underlying cause	given in Part I.	23b. Did	i tobacco	use contri	bute to t	he cause of death		
	P.0	v requires thet the death cer been signed by the ettendin should be deteched for use									1	Yes 2	No 3	Proba	bly 4 Unknow		
	ds,	signe d be d	l by								-			745 W/an	a autonou tindinan		
	O	requires been sign should be	Completed								perl	s an auto formed?	psy	com	e autopsy tindings lable prior to pletion of cause		
	Rec	2 8 0	mpi								100		1	ot de	eath?		
	a	w -		25 111								Yes 2	No	10			
	Division of Vital Records,	Physician: The law rithis certificete has the stand director, page 2 s	o Be	25. Was case rete examiner?	/	Hospital:			-5	O41					s et Mera		
	of	Phy oral	. To	1 ☐ Yes 2 Z 27. Menger of Dea		11		ER/Outp 28b. Tin	etient 3L DOA	4 LJ Nursing njury at Nork?	Home 5 Res				HOSPICE		
	on	ending Pheath.	tlor	Natural 2 Accident	5 Pending investigati		ot Injury nth, Day Year)	Inju		Vork? ☐ Yes 2 ☐ No							
1	N N	Dy th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Pled	a ot Injury - At he	ome, farm	n, street, tactory, offi	ce	28t. Location	(Street ar	nd Number	or Aural F	Route Number,		
1/1	ō	Refris arts mercal offi	Cert	4 El Hornicide		Dulk	ding, etc. (Specif	γ)			City or To	JWII, State	9/				
	15	Hospi A hoge tely fill	edicai	29e. Certifier (Check only	1 Certifying F	aminer: On the	basis of examina	wiedge, d	deeth occurred at the or investigation, in m	time, dete end ple y opinion, deeth oc	ca, end due to the curred et the time	ceuse(s) and mann d place, and	er as stat	ed. he cause(s)		
-	1	To the Howithin 24.11 To the Fun completely	Med	one) 29b. Signature and		and ma	nner stated.			ense number							
		5.14.8	200							D40854			29d. Date signed (Month, Dey, Year)				
						0 "					,		1.10	/-	/		

31. Dete tiled (Month, Day, Year) State Registrar

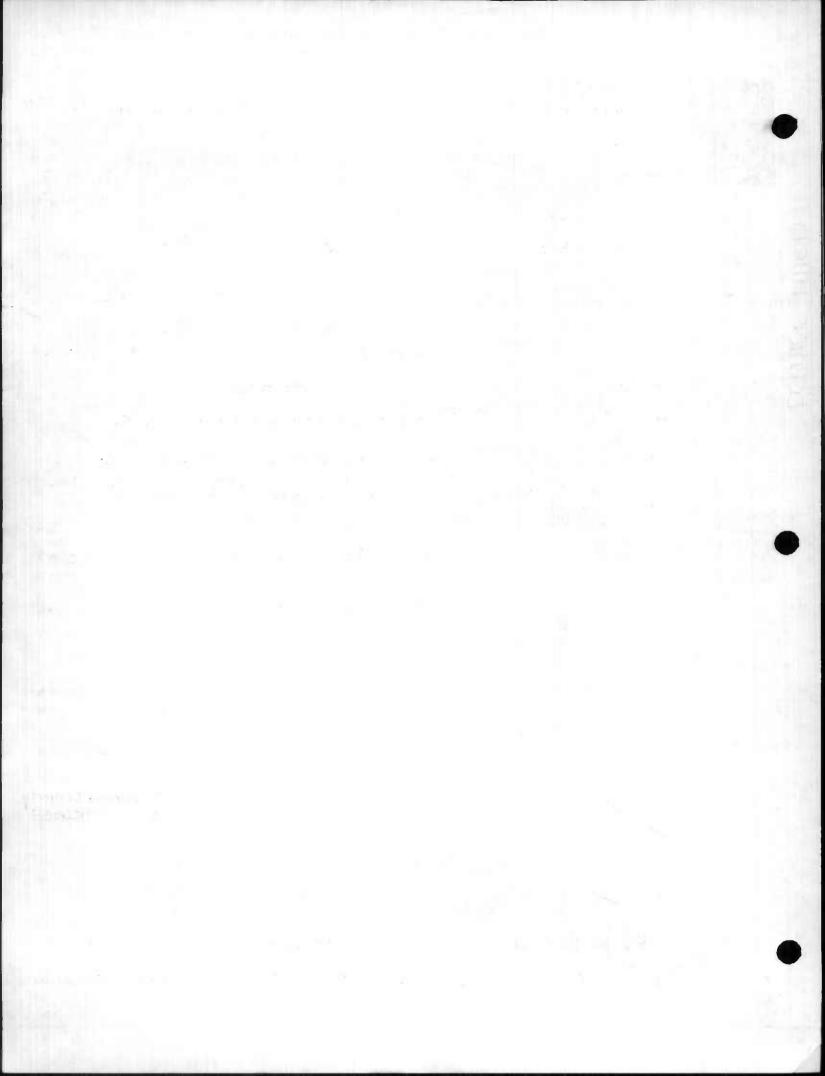
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dank A Restby, MD 4017

Baltinon, MO 21208

sol St Par PI

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 4.30 Am NOV BROWN M. 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE If Under 1 Year if Under 24 Hrs. UNION MEMORIAL NIA HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 10M 20F 422. 54. 2303 Deys Hours Yrs. LABAMA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No NIA BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3235 AVENUE Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2☑ No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) CUSTODIAN 11 TH GRADE IY AINTENANCE NA 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) SHERMAN TREEMAN ANNIE BERRY 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) BROWN SON BALTO. MD 3516 JOANN 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donation 5 ☐ Other (Specify) DRUID KIDGE CEMETERY 11-29-97 BALTO MD VAUGHN COS GREENE FUNERAL SER. 21. Signature of Funaral Service Licensee 23a. Part1. Enter the deeasa, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death 5 month Immediate Causa (Final non-small cell lung Cancer disease or condition rasulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting In the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed?

Physician /Medical **Examiner**

physician s the burial

signed by I

certificate

þ

Completed

Be

2

Certification:

edical

permit. Pages 1 and 2 s Department of Haalth er Important: If item 27 is any injury or other trau once.

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

Show

28a-f

ò items 23a Director

Funeral

by

Completed

traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after in ant of Haalth end Mental Hyglene. Int: If Item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0020

Saquentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Physician/Medical

25. Was cese referred to medical 26. Placa of Daath (Check only one)

completion of cause of death? 1 Yas 2 No 2 No 1 Yes

1 Yes 2 No

28a. Date of Injury (Month, Dey Year)

Hospital: 1 Inpatient 2 ER/Outpatlent 3 DOA 28c. Injury at Work? 28b. Time of

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Dascribe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Homicida

5 Pending investigation 6 Could not be

28e. Place of injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

PKWY. U.M. H. Baltimore. MD

29a. Cartifier (Check only one) the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

WANG 31. Dete filed (Month, Dey, Year) NOV 26 1997

20/E university 32. Registrar's Signature

30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)

M.D

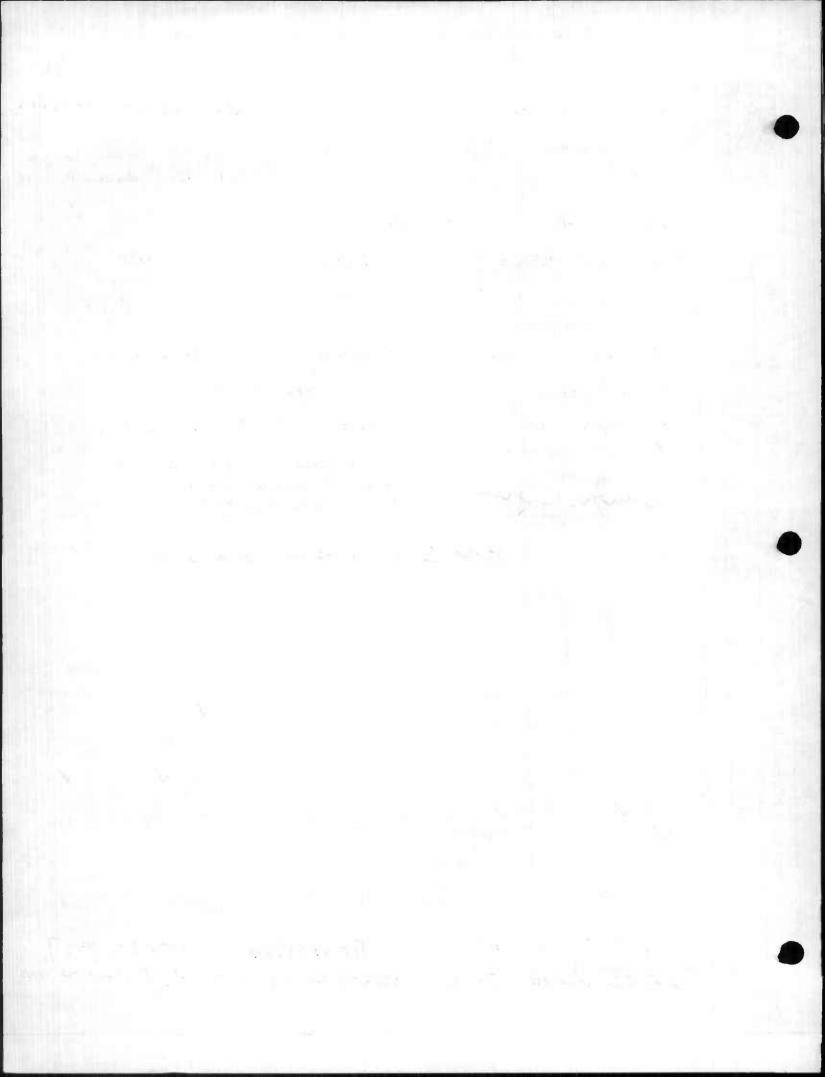
who Daydson Trandall

Registrar DHMH 16 Rev 6/95

Box P.O. Records, of Vital

68760,

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice Division To the Hospital within 24 hours of To the Funeral Completaly filled



State of Maryland / Department of Health and Mental Hygiene

RUSSELL **BROWN**

Physician /Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Certificate of Death

2. Date of Death

Russell Brown 4e. Fecility Neme (If not institution, give street end number)

97

18,1997 NOVEMBER

Year)

3. Time of Deeth 5:34P.M.

2324 ASHBURTON STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Deeth

Funeral Director

28a-f show

ö

238

'natural', or items

the

72 hours efter

Baltimore, Maryland 21215-0020

Examiner must be notified at

traumatic event, the Wedical

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than "

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau

Physician

Examiner

physician and s the bunal-trans

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After

To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: Al completely filled in by the fu

the death certificate be executed

Box 68760

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Records,

Division of Vital Attending Physician: Examiner

Physician/Medical

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Completed

Be

Certification: To

Medicai

Director

Funeral

by

Completed

10e. Stete

n/a

XXM 2 F

Months Yrs.

If Under 24 Hrs. Min. Hours Aug. 15,

 Birthplece (State or Foreign Country) 1900 Va.

577-03-5769 Usuel Residence of Decedent 10b. County

5. Sociel Security Number

Md.

10c. City, Town or Locetion Baltimore

7. Age (In yrs. lest birthday)

10d. Inside City Limits ¥Yes 2□No

10e. Street end Number

2324 Ashburton Street

10f. Zip Code 21216

If Under 1 Year

Days

10g. Citizen of Whet Country? USA

11. Maritel Stetus 1 Never Married 2 Merried 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 200No

14. Rece - American Indien, Bleck, White, etc. Specify: Black

3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementery/Secondery (0-12) unknown

Truck Driver

DNA Distributor

17. Fether's Neme (First, Middle, Lest)

Charles Brown

Lucy

18. Mother's Name (First, Middle, Maiden Sumeme) unknown

19e. Informent's Neme/Reletionship (Type, Print) daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2324 Ashburton Street Baltimore, Md. 21216

Frances Coates 20e. Method of Disposition

1 Purlai 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) 5 Other (Specify)

20b. Plece of Disposition (Neme of cemetery, crematory or other place) Mt. Calvary Cemetery

20c. Location - City or Town, Stete Nov. 25Baltimore, Md.

22. Neme and Address of Fecility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls PKWY Baltimore, Md. 21216 hal caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest,

ate Ceuse (Final or condition g in death)

Due to (or es e consequence of):

Due to (or es e consequence of):

Due to (or es e consequence of)

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest

Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.

Rectal Carcar and aly.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

INSPECTION

24e. Wes en eutopsy performed?

24b. Were autopsy findings evelleble prior to completion of ceuse of deeth?

1 ☐ Yes 2 No

25. Was cese referred to medical exeminer?

1X Yes 2 No

5 Pending

investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

28c. Injury et Work? 1 Yes 2 No

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

111 Penn Street, Baltimore, Maryland 21201

1 ☐ Yes → No

29a. Certifier

Megner of Deeth

Nature.

2 Accident Naturel

3 Sulcide

4 Homicide

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) end manner steted.

29c. License number

O.C.M.E.

29b. Signeture end title of certifier

29d. Dete signed (Month, Dey, Year)

Wodone 30. Name and eddress of person who completed cause of death (May 23a) (Type, Print)

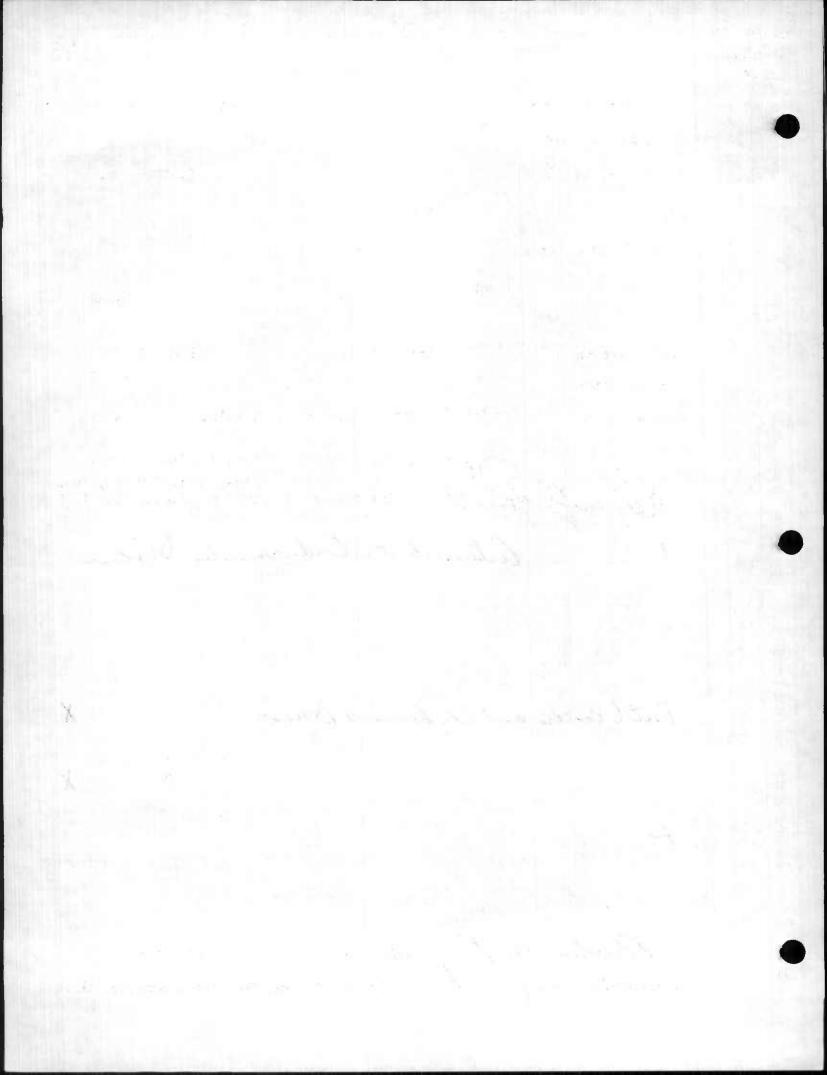
en. 0),

NOVEMBER 19, 1997

HEODORE MIKIT

82. Registrar's Signature arean fonders

State Registrar



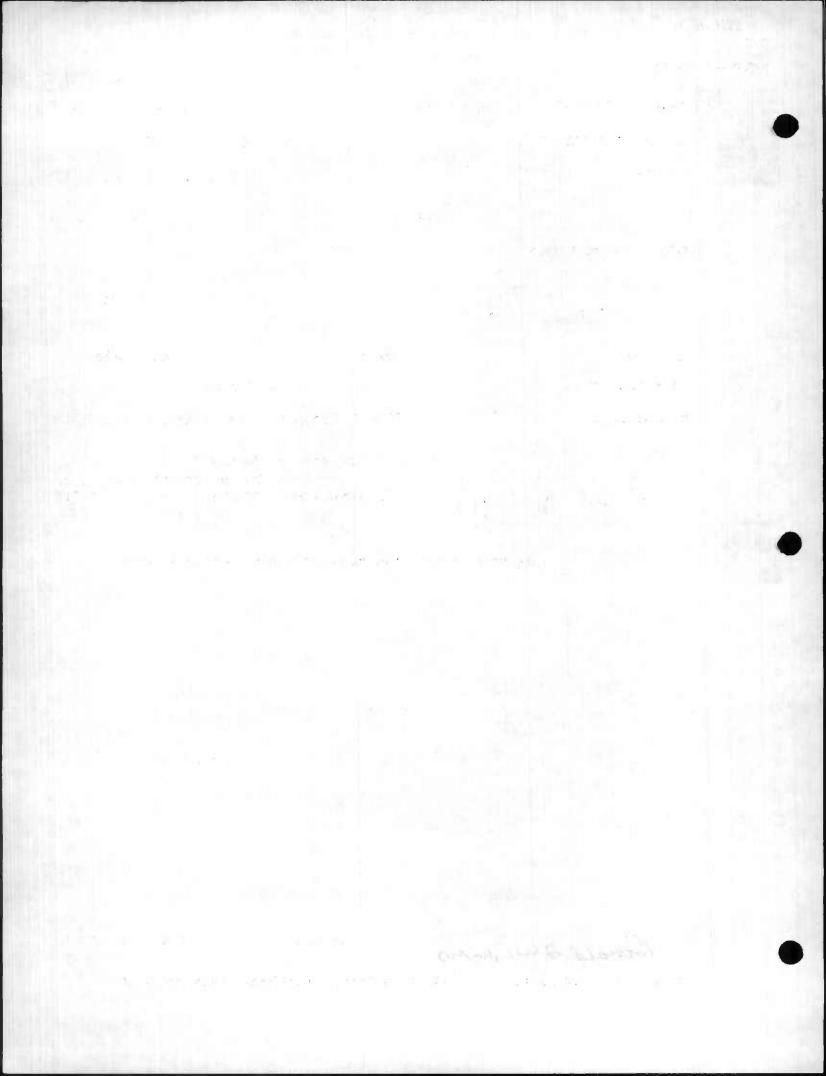
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B.K.S HEXEKL	AH .	BROWN						ent of H	. Assure A lealth and I Death	Mental Hy	9	7 35010
Physic /Med			Hezekiah		Brown	, Jr.			2. Date of De Month NOV 1	Day .5, 1997		
Exam	iner	4a. Facility Name (ım <i>ber)</i>			1	4b. City, Town, or I			1/0-2
Funera Director		5. Social Security N 212–26–66			7. Age (In	yrs. last bir	thday) If U Yrs. Mon	ndar 1 Yaar ths Days	BALTIMO If Under 24 Hrs. Hours Min.		ly, Year)	Birthplace (State or Foreig Country)
pud *		Usual Residence of	Dacedent 10b. County		100	City Tow	n or Location					
Maryla	10	Md.		/a		altim						10d. Inside City Llmit
h with the	Funeral Director	10e. Street and Nur 2919 Rock		nue	10f. Zip Code 21215						10g. Citizen of USA	What Country?
72 hours efter death with the Maryland natural; or items 23a or 28a-f show on the first result to mutited at	þ	11. Maritai Status 1 Naver Marri 3 Widowed	ied 2□ Marriad	12. Was Dec Armad Fo 1 XYes If Yes, Gi Year or D	orcas? 2 ☐ No ive	in U,S. 1 94 6 1947	If Yas,	ecedent of H specify Cuba es 2000	lispanic Orlgin? (S an, Mexican, Puart Specify:	pecify Yas or No o Rican, etc.)		ca - Amarican Indian, ck, White, etc.
d within 72 hours of jiene "netural", or then "netural", or	Completed	(Special Control of Co	15. Decedent's E cify only highast gra andary (0-12)	ade completed)	1-4or 5+)		6a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)			king		usiness/industry
tal Hy	o Be Co	10th Grad 17. Father's Name Hezekiah				Cu	stodia	n	18. Mother's Nan	College ne)		
E = 01 L		19a. Informant's Na Marlene D	ame/Relationship (Турө, Print) п	iece	196			and Number or Ruenwood Av			, State, Zip Code) , Md. 21213
		20a. Method of Disposition 1										City or Town, State
permit. Pages Depertment of Important: If II any Injury or		21. Signature of Fu	neral Servica Lice	X U	rsy (1	22. Nam	e and Addre	ss of Facility N	lutter F	uneral 1	Homes, Inc. , Md. 21216
tificate be executed Medical Examiner as the burial-trensit	edical Examiner	Immediate Cause (disease or condition resulting in death) Sequentially list confiant, leading to incause. Enter Under Cause (Diseasa or that initiated events resulting in death) is	nditions, nmediate rhying injury	a. Hyper	Due	to (or as a	terios consequence consequenca	of):	tic Card:	iovascul	ar Dise	Onset and Death
death certificete e attending physic for use as the	Physician/M	Datil On alask		d								
d by the	by Physi	Pert II. Other eignif	icant conditions of	ontributing to d	eath but not	t resulting in	n the underlyi	ng cause giv	en in Part I.			ontribute to the cause of death
The law requir ate has been s page 2 should	Completed									INSPE	an autopsy med? CTION Yes ACNO	24b. Were autopsy findings available prior to completion of causa of death? 1 Yes 2 No
Physician: The this certificate ral director, pag	Be	25. Was case refer examiner?		Hospital:				044	26. Place of Dea	th (Check only o	one)	
Phys aral di	ition: To	1) Yes 2□ 27. Manner of Daatl 1 Natural 2 □ Accident		28a. Date (Mon	Inpatient of Injury oth, Day Yea	28b. 7	Itpatient 3 Time of njury M	DOA Oth	4LI Nursing H	ome XX Residence 1	denca 6 Oth	
al or Attending s after death. f Director: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28a. Placa	M 1 ☐ Yes 2 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (S City or Tov	Street and Numi	ber or Rural Route Number,
n 24 hours a	edical C	29a. Certifier (Check only one)	1☐ Certifying Ph 2☐Madical Exam	niner: On the b	best of my asis of exar ner stated.	knowledge mination an	, death occur d/or investiga	red at the tin tion, In my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and piaca,	anner as stated. and due to the cause(s)
To the transfer of the transfe	Me	29b. Signature and		7. Chi	the A	10		29c. Licens	e number .M.E			d (Month, Day, Year) 15, 1997
x\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201										

6x State Registrar

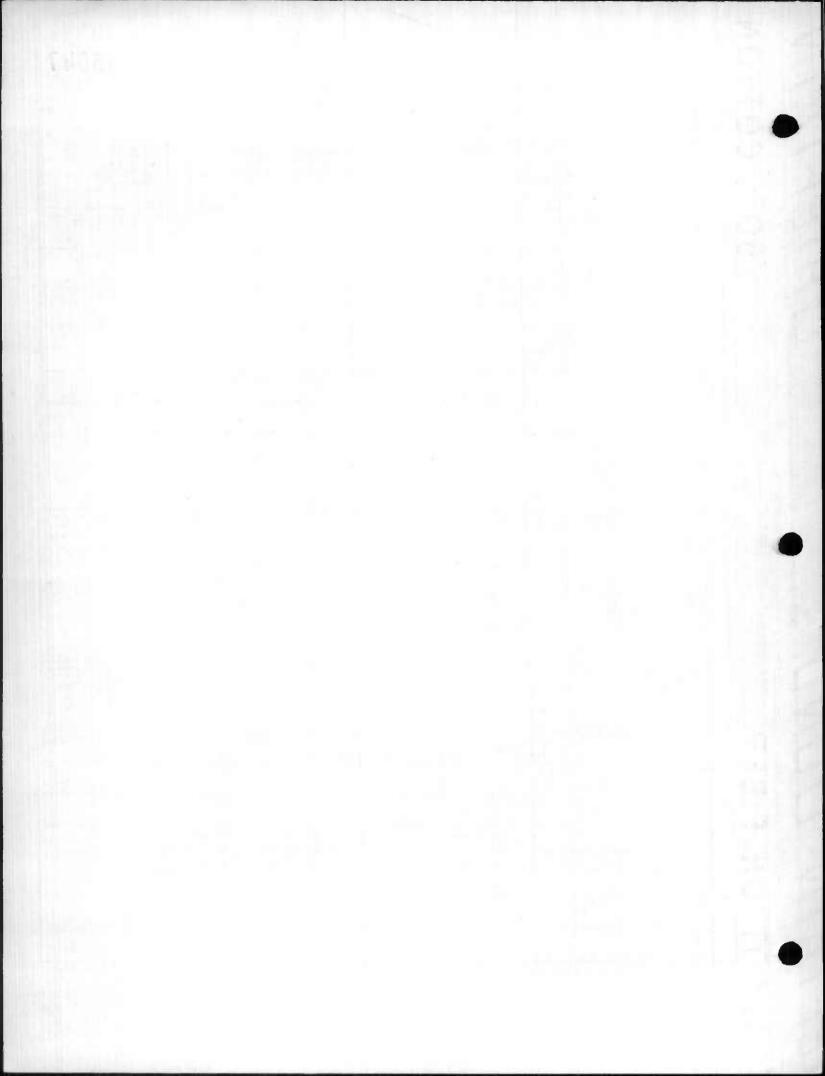
31. Date filed (Month, Day, Year) NOV 2 6 1997





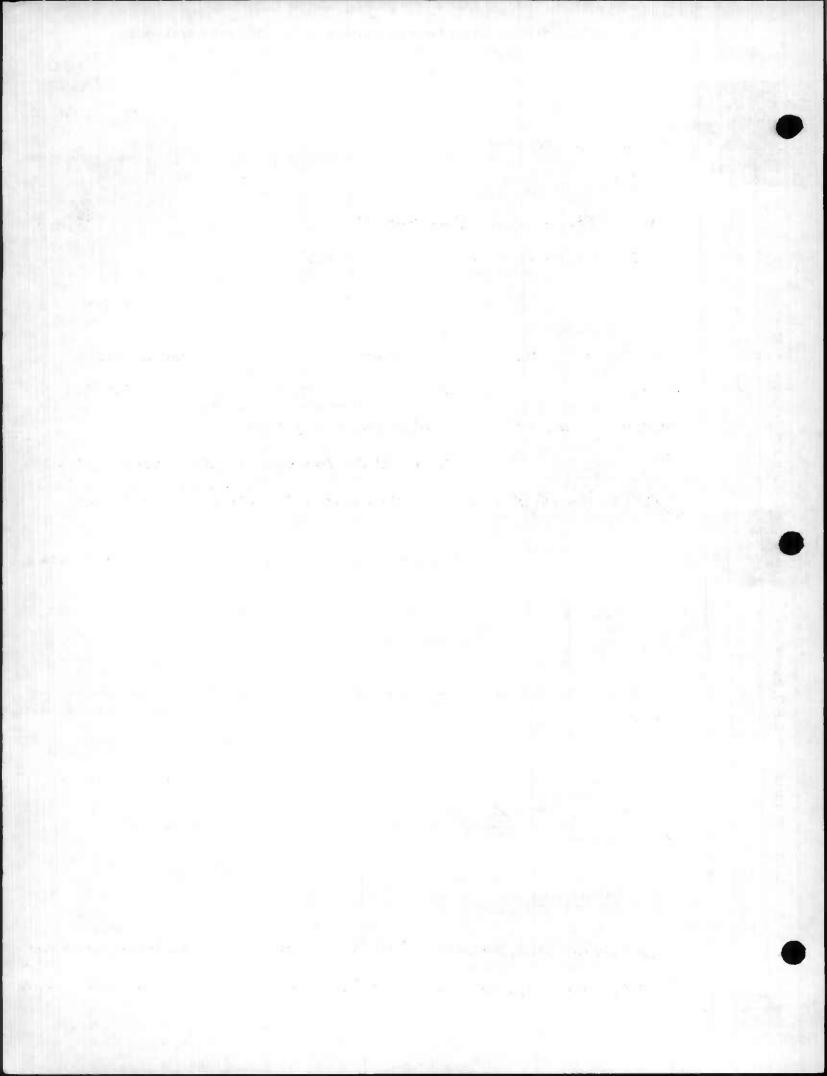
DIVISION OF VITAL RECORDS, P.O. BOX 13146, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an increase of the funeral director, page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 hours after death with the State Dept. of Health and Mental Hyghen prior to burial, cameration, or removal. IMPORTANT: If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR		STATE OF N		D / DEPARTI		EALTH AND DEATH	MENTAI	HYGIENE REG. NO.				
1. DECEDENT'S NAME	(First, Middle, Last) PETRU	DE B	BERI	MAN		1000000	OF DEATH DAY	3.	130 Am			
4. SOCIAL SECURITY 219-38-	2403	5. SEX	6. AGE (In yrs	7 YRS.	F UNDER 1 YEAR DNTHS DAYS	IF UNDER 24 HRS. HOURS MIN,	NO\	of BIRTH 1, Day, Year) 7.24,190	09 1	Country) MARY	ACE (State or Foreign	
90. FACILITY NAME (N	is LON	GG REE	N Nun	SING Hom	b. CITY, TOWN C	ALTO:	EATH		9c. COUNTY	OF DEAT	ГН	
RESIDENCE OF 100. STATE MD	10b. COUNTY	V/A		10c. CITY, 1	BALTIM				-		d. INSIDE CITY LIMITS?	
100. STREET AND NUI 115 E. 11. MARITAL STATUS 1 Never Married	MELROSE A	VE			101	21212				USA		
11. MARITAL STATUS 1 Never Merried 3 Wildowed 4	2 Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	NO		an, Puerto I	1? (Specify Yea or Rican, etc.)	7	Black, White, atc. Specify: WHITE			
(Spec	0.71	CATION completed) College (1-4 or 5	+)	Give kind of wor life. Do NOT use r	k done during mo etired.)	16b	KIND OF BUSIN					
17. FATHER'S NAME (F	12 First, Middle, Last)			HOMEMAKE	ER .	16. MOTHER'S NA	AME (First, I		HOME			
WILLIA	М		WEINB	LATT		MIN	NIE		SPEVAK			
D 198, INFORMANT S NA				- The state of the		nd Number or Rural					- 01000	
1 Donation 5 D	matton 3 Bem	oval from State	oth	er place) LTIMORE		The state of the s	20/97		STERS			
21. SIGNATURE OFFI		tellman	,	321110143	SOL	DEVINSON	& BI	ROS., I	NC.		E, MD 2120	
23. PART I. Enter ahock, IMMEDIATE CAUS disease or conditi resulting in death; Sequentially list or if any, leading to it cause. Enter UND CAUSE (Disease of thet initiated even resulting in death)	or heart failure. E (Final on) onditions, immediate ERLYING or injury to	a. Due To	OR AS A CO	NOTION OF OF OF OF			4				Approximate Interval Between Onset and Death	
PART I Wither sig	nificent condition				tha underlyin	g cause given in	Part I.	24e. WAS AN AI PERFORM 1 YES 2	ED?	AA Ct	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATHY YES 2 NO	
25. WAS CASE REFER	RED TO MEDICAL				26. P	ACE OF DEATH (C	hack only or	70)				
EXAMINER?	6	HOSPITAL:	ER/Outpatia	nt 3 🗆 DOA 4	THER:	ne 5 🗆 Residence						
25. WAS CASE REFER EXAMINER? 1 YES 2 27. MANNER OF DEAT	5 Pending	28a. DATE Of (Month, I		28b. TIME	OF 28c. IN.	URY AT ORK? YES 2 NO		SCRIBE HOW INJ	URY OCCUP	ED		
2 Accident 3 Suicide 4 Homicide	2 Accident Investigation 28e PLACE OF INJURY At home farm street factors office 28t LOCATION (Street and Alumber of										te Number,	
29a. CERTIFIER (Check only one) 29a. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, dasth occurred at the lime, date and place, end due to the cause(s) end manner as stated.											nd manner as stated.	
29th. SIGNATURE AND DO 30 NAME AND ADDRI	luc of	· Su	kir	MI) 1	D ZZ	GF1	5	29d. DATE S	19	10g(h, Day, Year)	
FRED	Ric S.	SI'ICK	SE OF BEATH	11 D, 7/	51 40	CABIR	DA	VE, BA	16.	mi	22215,0	
31. DATE FILED (Month	2 6 1997	32. REGISTA	Laura Son	n-Pandall								



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** ROBERT CARTER NOVEMBER 22 1997 /Medical 5:37 am 4a. Facility Name (If not Institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL NA BALTIMORE CITY If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foraign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1√2 M 2□ F Months 51 Yrs. Director 214-46-2687 09-22-46 Md. Usual Residance of Decedent the Manyland 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Director Centreville Queen Annes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23a 419 South Liberty Street 21617 USA Funeral 12. Was Decedant Evar in U,S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. filed within 72 hours effer Hygiene. ther than "natural", or ite 1 Never Married Married 1 ☑ Yes 2 ☐ No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 end 2 should be filed wi Department of Health, end Mental Hygien, Important: if item 27 is marked other thy any Injury or other traumetic event 12th Grade Artist Facilities 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Robert Carter 2 Emma Griffin 19a. Informent's Name/Relationship (Type, Print) 19b. Maifing Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) Yvonne Carter 6130 Dunroming Road 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriaf 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Chesterfield Cemetery 11-28-97 Centreville, Md 21. Signature of Funeral Service License 22. Nama and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Pulmonery Embolus tour weeks Examiner Due to (or as a consequence of): Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physician and for use es the buriei-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown HIV Records, þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 200No certificate Division of Vital Hospital or Attanding Physician: 24 hours effer death. 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only ona) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After Neturel 5 Pending Investigation 1 Yes 2 No d in by the f 2 Accident 3 Suicide 8 Could not be 28e. Pfece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) To the Hospital or At within 24 hours effer or To the Funeral Direct completely filled in by 4 T Homicide 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) Sunjay Kaushal, Surgical Intern RES-000 November, twenty-two, 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sunjay Kaushal, 600 N. WOLFE STREET, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD NOV 2 31. Date filed (Month, 32. Registrar's Signature State Julia Savidson-Randall Registrar



Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

OCME

111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

NOVEMBER 24, 1997

State

29b. Signature and title of certifier

LARON

31. Dete filed (Month, Day, Year)

and address of person who complated causa of deeth (Itam 23a) (Type, Print)

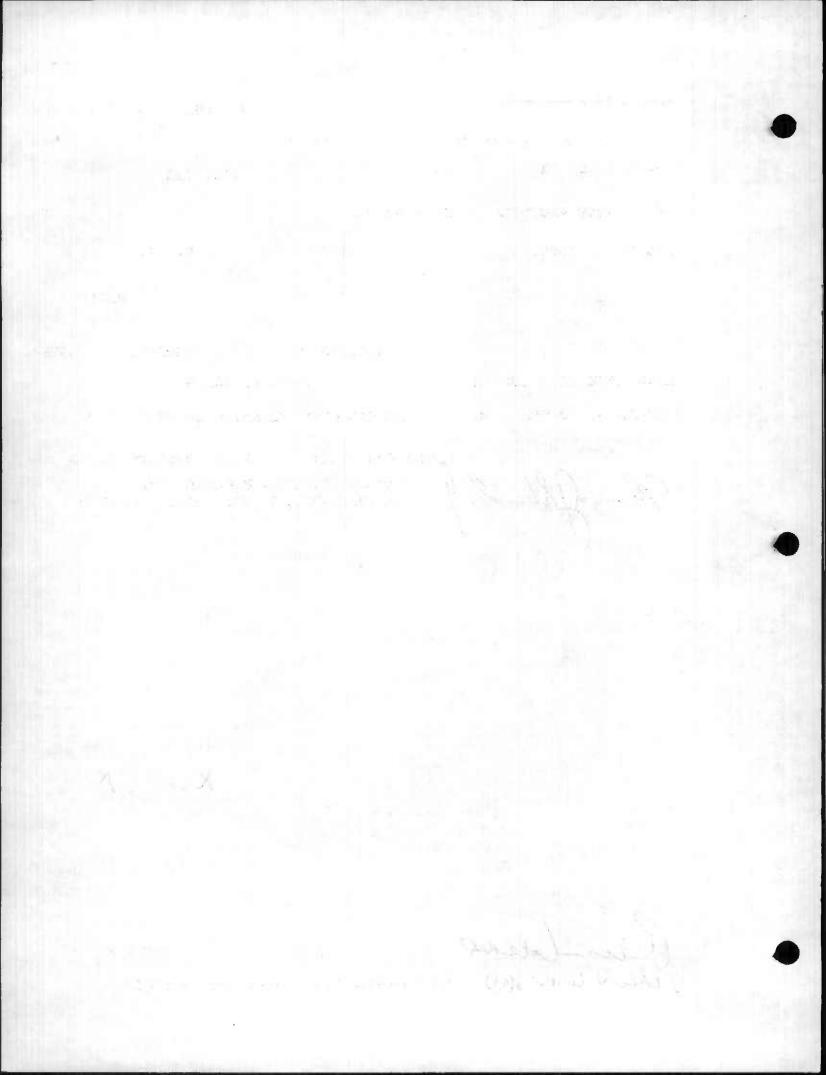
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32. Registrar's Signatura

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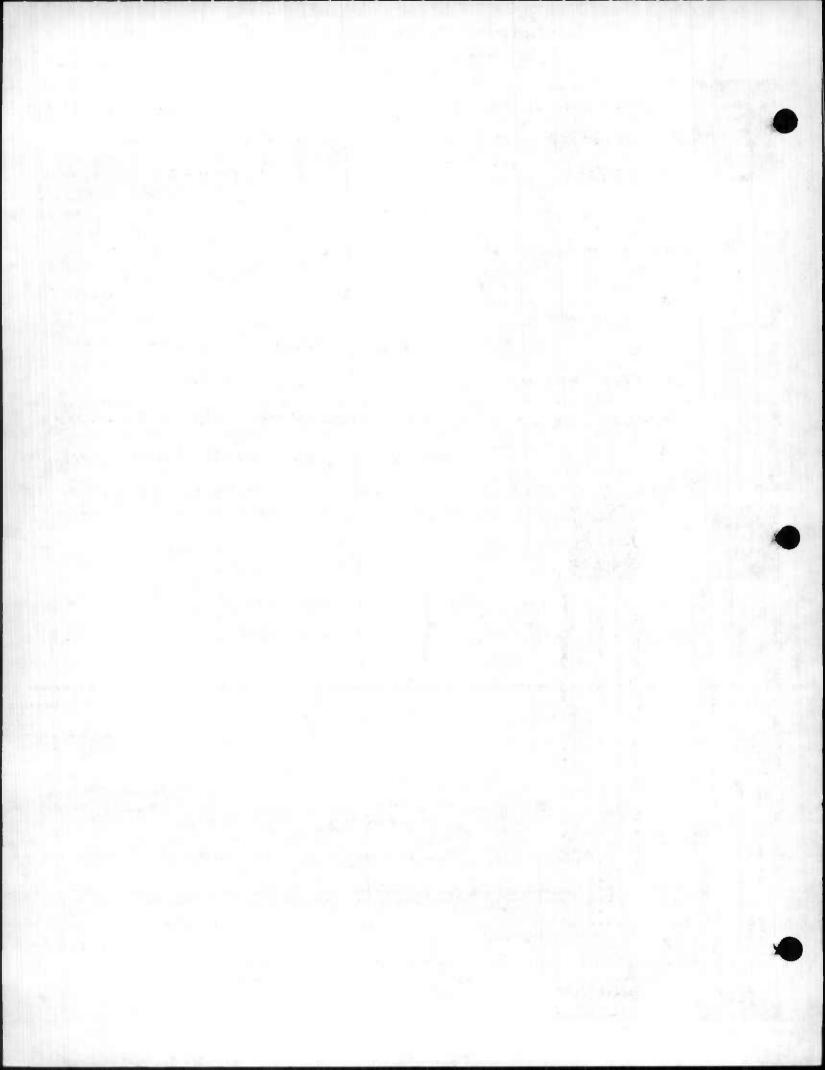
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xaminer	-	Mercy Hos		< e			Bak	vn, or Lo	ocation of Daat		y of Death			
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or zea-t show o notified at		10a. Stata 10b. County			M or Location							10d. Insida City Limits		
ust be notified at		10a. Street and Number	non st		1	Zip Coda	<-			10g. Citizen of	What Cour			
or items iminer m		11. Marital Status 1 Navar Marrlad 2 Married 3 Widowed 4 Divorced	12. Was Decadant Ev Armad Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:		13. Was De If Yas, s	cedant of I	Hispanic Orig an, Maxican,	in? (Spi Puarto	acify Yas or No Rican, atc.)	- 14. Ra	ce - Amaricack, Whita,	can Indian,		
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or traumat		19a. Informant's Name/Raiationship GRACE ME					and Number	r o <i>r R</i> ura	al Routa Numb	nber, City or Town, State, Zip Code) ALTO M. J. 2, 2, 4				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month CORnell MRL 0830 22 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth n/a BAZTIMENE SALT MED If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Months Deys 120M 2□ F 75 214-18-5107 March 30, 1922 Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore Yes 2□ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 1815 Ashburton Street 21216 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American indien, Black, White, etc. Yes 2 □ No If Yes, Give Yeer or Detes: 15 Never Merried 2 Married 1 ☐ Yes XX No Specify: Black 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Mercantile Bank Vault Attendant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Miller Louis E. Cornell unknown 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Arlene Coates niece 1815 Ashburton Street Baltimore, Md. 21216 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Nation 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Garrison Forest VeteransNov.28 Owings Mills, Md. 21. Signeture of Funeral Service License 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause of each line. Approximete Intervei Betwe Onset end Deeth Immediete Ceuse (Finel disease or condition resulting in deeth) Due to (or es e consequence of): Q Sequentielly ilst conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. Stete

Md.

Director

Funeral

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Completed

Be

Funeral

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28a-f show

6 items 23a

traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours effer in ord of Health and Mertal Hygiene. In: If item 27 is run-ried other than "natural; or ite iny or other traumatic event, ins had all fauralinates.

Baltimore, Maryland 21215-0020

the Maryland

Examiner

Physician/Medical the ed by the a signed b þ page 2 should Completed certificate director, Be Medical Certification: To After

The law requires that the death certificate be executed Box 68760. P.O. I Records, Division of Vital offer death.

Director: After this certifications by the funeral

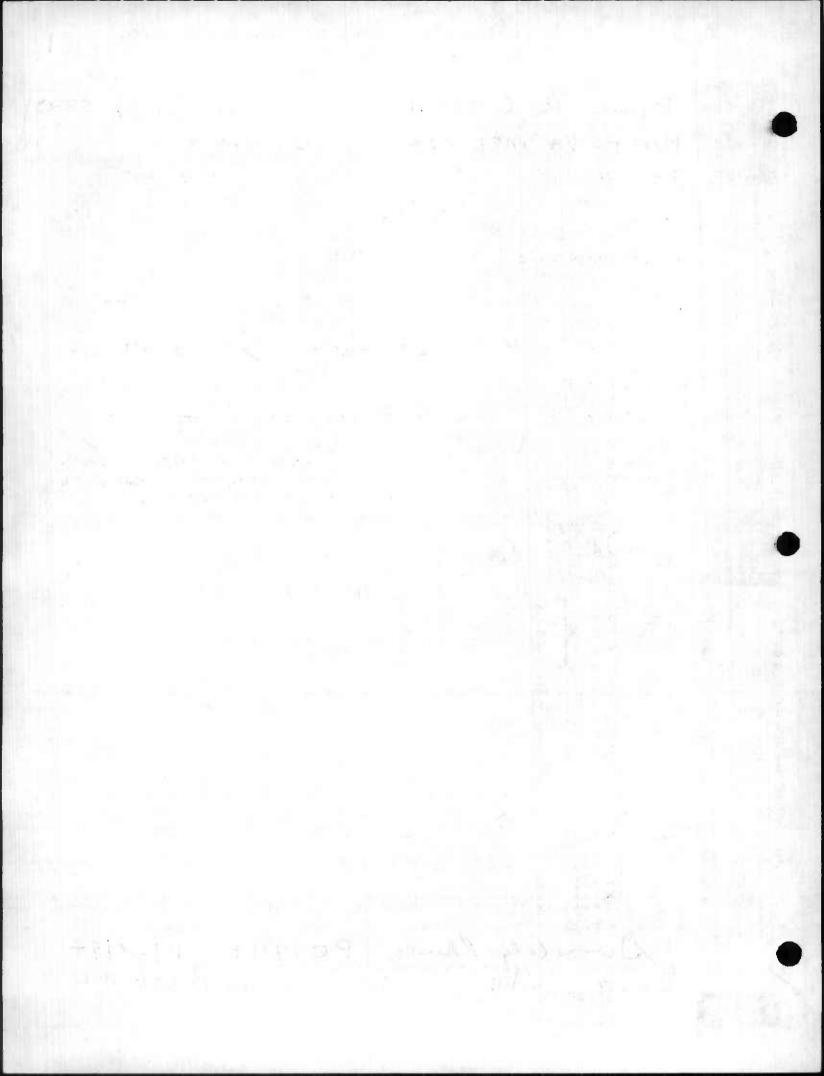
Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was cese referred to medicel exeminer? Hospitel: 12 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No 27. Menner of Deeth 28a. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

TU 31. Dete filed (Month, Dey, Year) NOV 2 6 1997

30. Neme and eddress of person who completed cause of deeth (item 23a) (Type, Pript) 32. Pedistrar's Signature



State of Maryland / Department of Health and Mental Hygiene 9.7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth **Physician** Month 4:16 a.m. Rathakrishnan Dandapani November 22, 1997 /Medicai 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Silver Spring Holy Cross Hospital Montgomery 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys 15 M 2□ F Hours 70 Yes 219-98-7243 Director 10-08-1927 India Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Haelth and Mental Hypiena. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified anones. 1 No Yes 2 No Prince George Adelphi Director Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20783 1919 Redoak Drive India Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Merried 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Asian Indian by 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondery (0-12) Cotlege (1-4or 5+) Health Care 12 4 Nursing Supervisor 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Rathakrishnan Setambaram Thayarammal (unavailable) 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Adelphi, Maryland 20783 Udayasankar Dandapani/Son 1919 Redoak Drive 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-23-97 Laurel, Maryland Balt. Wash. Crematory 21. Signature Funerei Service License 22. Name end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset end Deeth Physician Immediete Cause (Finel disease or condition resulting in death) /Medical Endstage veral 3 month Examiner Due to (or es e consequence of): 10 Jean. COYONGY gitcij Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of)s be exe Box 68760, dan. Failure espirala. Be Completed by Physician/Medical Due to (or es e consequenca of): Dilegie Jedn. INNS for usa P.O. signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown mellily Records, 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? pertensive Heart Habelparcialis 1 Yes 20 No 1 ☐ Yes 2 No Division of Vital I or Attending Physician: after death. Director: After this cartifice 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 2 4 I Homicide filled 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a, Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signettyre end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) D HIIC 2 MD 11-22-97 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 19529 Doctori Dying Germanteum mp 20874, CM

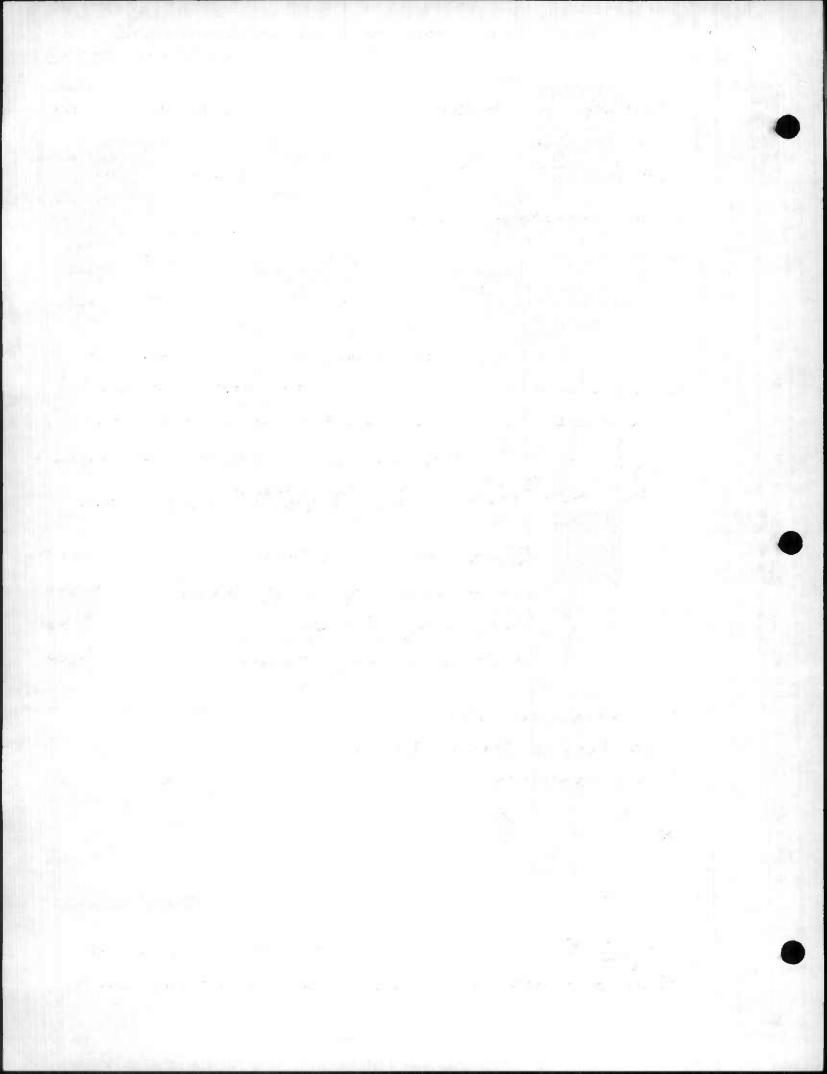
State Registrar Codup.

26

32 Registraria Signature

we Daydson-Randall

VAIN 31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 27 AM Month Year BERNADETTE NOV DIGGS 7 1997 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth HOSPITAL BALTIMORE SECOURS If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1□ M 2₽ Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yas, Giva Year or Dates: 1 Never Married 2 Married 1□ Yes 212 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden BERVART 19e. Informant's Name/Relationship 20b. Place of D 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removel from State 4 Donation S ☐ Other (Specify) 21. Signature of Eunaral Service Licensii e, or complications that caused tha deeth. Do not enter the mo-List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition rasulting in death) Dua to (or as a conse Sequentially list conditions, if any, laading to Immediate cause. Entar Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Dua to (or as a consequence of): Due to (or as e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings avallable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 26. Place of Death (Chack only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Inpatient 28b. Tima of 28d. Describe how injury occurred

/Medicai Examiner burial-transit pue physician s the burial P.O. Box 68760. Physician/Medical 98 0 signed by to Records. by cate hes been sig. Completed this certificate hes of Vital Be Lo Certification: Affer Division or Attanding death. efter death

Physician

/Medical

Examiner

10a State

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Funeral

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show

item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Modical Examinan Examination outlind at

Pages 1 end 2 should be filed within inent of Health end Mantal Hygiena. Int: If Item 27 Is marked other than "rury or other treumstic event, In Man

permit. Page Department of Important: If any Injury or

Physician

the Maryland

Baltimore, Maryland 21215-0020

25. Was casa raferred to medical examiner? 1 Yes 27. Manner of Daath 5 Pending investigation Natural Accidant

6 Could not be determined

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. injury at Work? 1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

(Check only 29b. Signature and title of certifie

Medical

State

Registrar

3 Suicide

4 Homicide

Certifying Physician: To tha best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

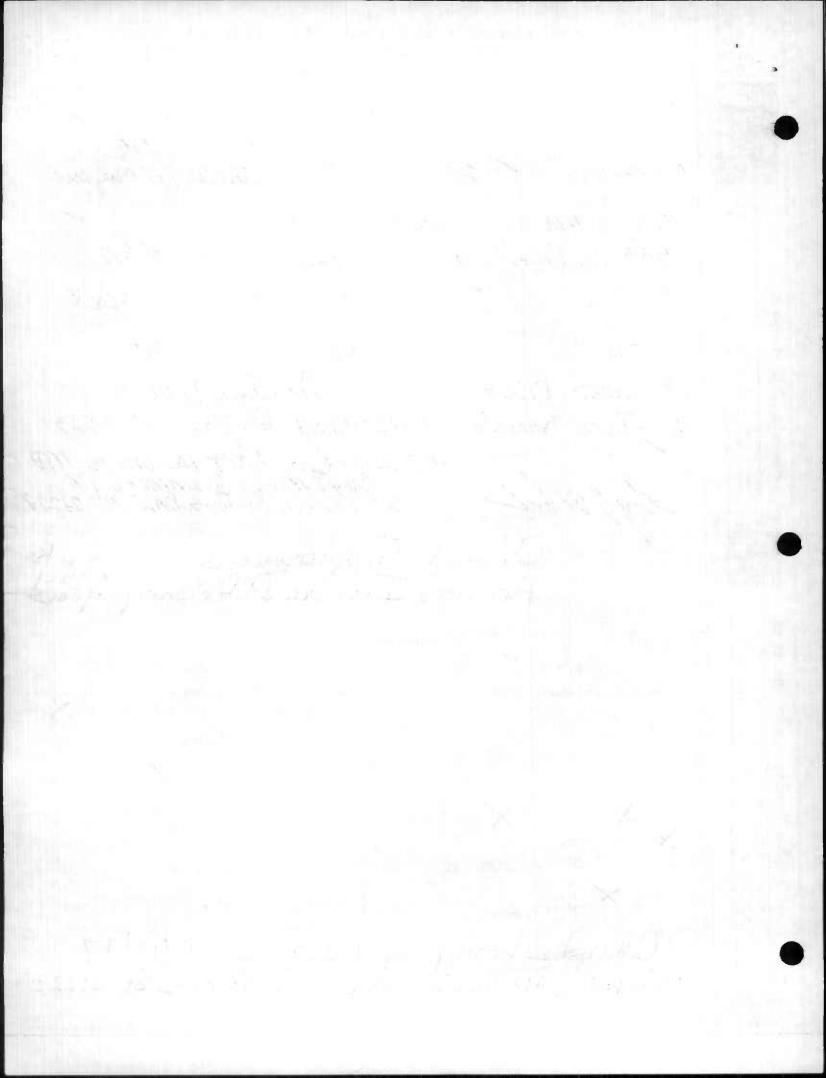
29d. Dete signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item

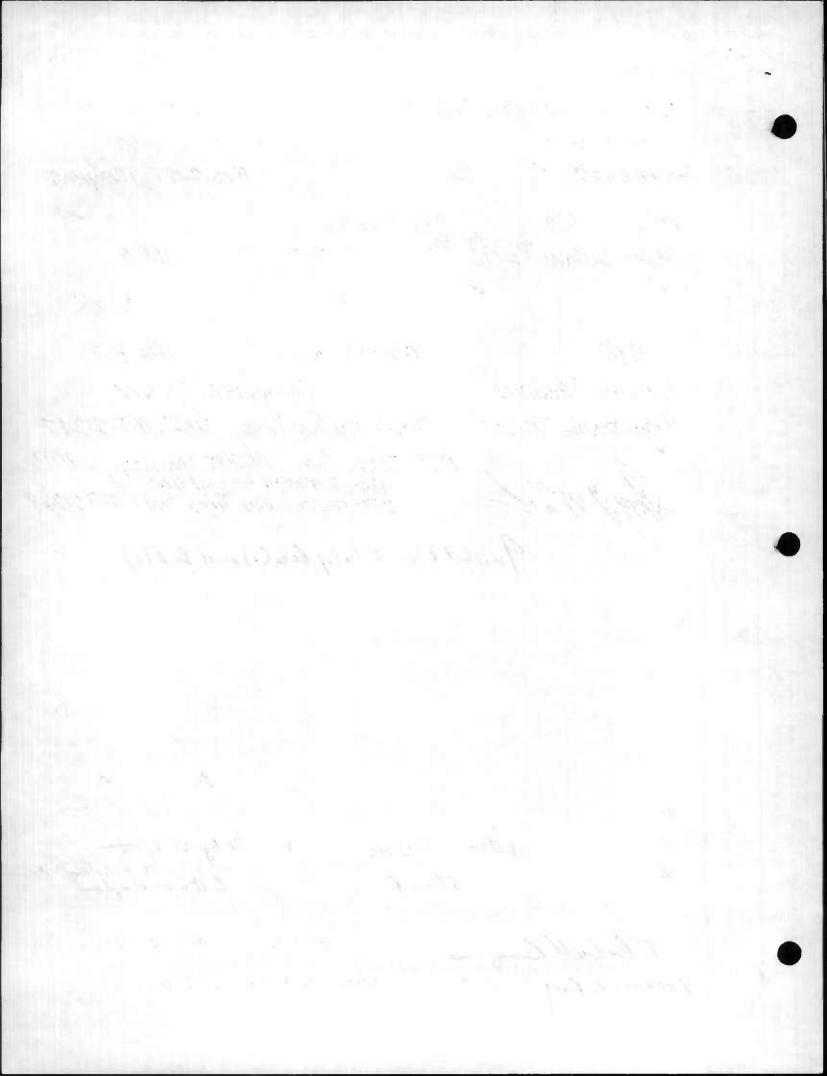
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23a) (Type, F

To the Hospital or within 24 hours of To the Funeral D

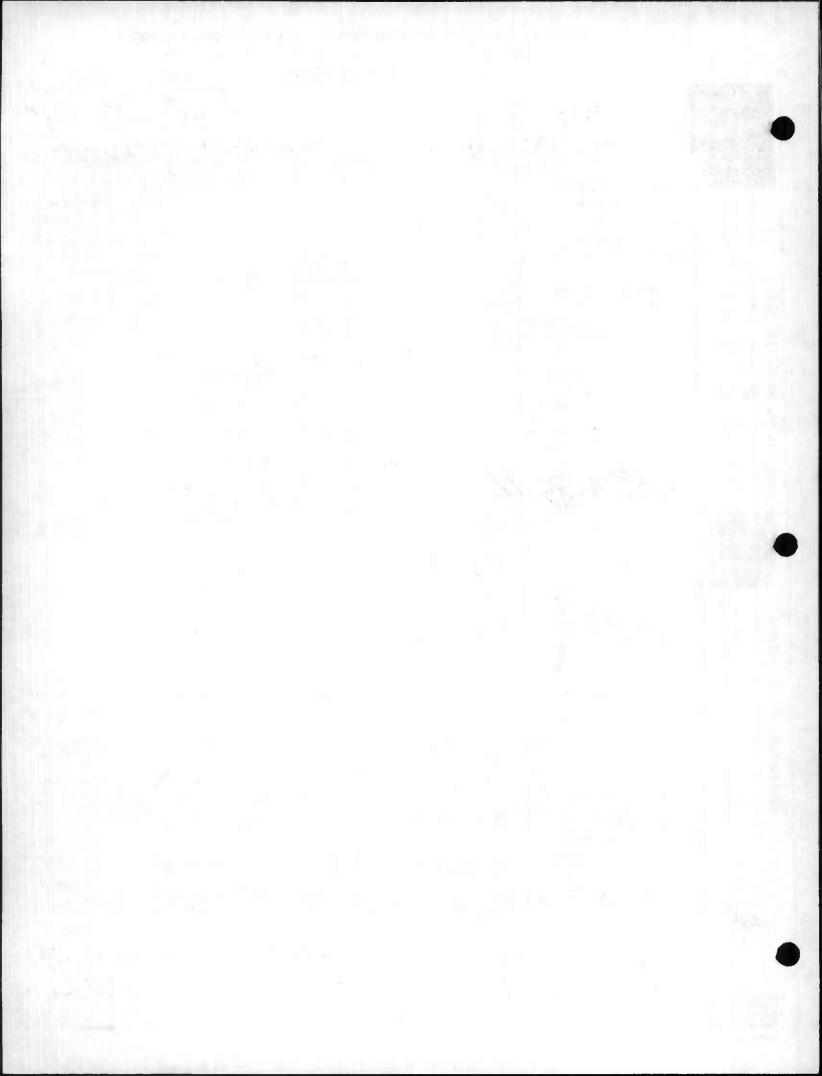


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Funeral Director		1607 W. NORTH AVE. 5. Social Security Number 6. Sex 120 F 20 Yrs. 1 If Under 1 Year Months Days Usuel Residence of Decedent	BALT] If Under 24 Hrs. Hours Min.	8. Date of Birl	h Year)	9. Birthplece (State or Foreig			
oth with the Maryland 23a or 28a-f show	Director	Usuel Résidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location ND, NA BALTIMORE			10d. Inside City 1 Pres 2				
72 hours after deeth with the Maryland natural', or farms 23s or 28s-f show acel Examinet must be notified at	Funeral	10e. Street and Number 2525 10f. Zip Code 11. Maritel Status 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Merried 1 Yes, Specify Cubs		ecify Yes or No Rican, etc.)		e - American Indian, ck, White, etc.			
d within giene. r than "	Completed by	3 Wildowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) I Yes, Give 1 Yes 2 Divided 1 Yes 2 Divid	petion during most of worki	ing	Specify: Black 16b. Kind of Business/Industry MAR K57				
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Physician /Medical Examiner phue end phue-Itausit phue-It	Examiner	Immediate Ceuse (Finel disease or confibilications that caused the death. Do not enter the mode of dying the disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate				Interval Between Onset end Deeth			
death certificate be executed e attending physician end of for use as the buriel-transit	edical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): d.				230			
that the cled by the detached	by Physician/M	Pert II. Other elgnificent conditions contributing to deeth but not resulting in the underlying cause give	ren in Pert I.		robacco use co Yes 2□ No	antributa to the cause of deat			
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Physician: r this certific ral director,	To Be	25. Wes case referred to medical exeminer? Mayes 2 No	4 Unursing Hor	(Check only one 5 Residue)					
To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	edical Certification:	3 Sulcide 3 Sulcide 4 Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify). 29a. Certifier (Check only) 2 Wedical Examiner: On the basis of examination and/or investigation. In my or	ne, dete end plece,	and due to the	cause(s) end me	er or Rural Route Number, 0 + West Neg - Av 1 - Vest Neg - Av 1 - Vest Neg - Av 1 - Vest Neg - Av			
To the Hospital within 24 hours a To the Funeral C completely filled	Medi	29b. Signeture end to of certifier 29c. License				d (Month, Dey, Year)			
Sta	te	30. Name and address of person who completed calls of death (Item 23e) (Type, Print) 111 Penn Street, 31. Date filed (Month, Dey, Year) 32. Registrar's Signature	, Baltimor	re, Mary	yland 21	1201			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

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uneral irector		5. Social Security 219-18		Sex 7. A/9e 1 □ M 2/1 F	(In yrs. last birti	rs. If Under 1 Yeer Months Deys	If Undar 24 Hrs. Hours Min.	8. Dete of Bird (Month, Da	h y, Year) 1022 Ma	Birthplece (State or For Country)				
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6 0	by Funeral Director		erried 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Giva Year or Detes:		1 ☐ Yes 2 No		Hican, etc.)	Biack, W Specify:	White, etc.				
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97-6761-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene LUKE Certificate of Death DONNELLY 1. Decedent'a Nema (First, Middle, Last) 2. Dete of Deeth Month **Physician** Luke Andrew Donnelly NOVEMBER 22, 1997 05:15 AM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** N/A SHOCK TRAUMA UNIT BALTIMORE if Under 1 Year If Undar 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2 □ F 219-08-6767 18 Yrs Director APR. 19, 1979 California Usuel Residence of Decedent the Maryland 10e. Stete 10b. Count 10c. City, Town or Location 10d. Ineide City Limits show 1 Yas 2 No Director Anne Arundel 28a-f Hanover 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? ò items 23a 894 Timberridge Drive 21076 Funeral USA Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Dacadent Ever in U,S. Armed Forces? Raca - Amarican Indian, Bieck, White, etc. 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Detes: 21215-0020 netural', or 1 ☐ Yas 2 No Specify: py Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry than Elamantary/Secondary (0-12) College (1-4or 5+) Hygiene. 8 Warehouseman Distr./Freight Carrier other Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) th and Mental I Be 2 should be Dennis Andrew Donnelly Kathleen R. Crook 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stete, Zip Coda) 19e. Informent's Nema/Ralationship (Type, Print) item 27 is other tra Dennis A. Donnelly - father Peges 1 and 894 Timberridge Drive, Hanover, Md. 21076 20b. Pleca of Disposition (Neme of cametary, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 11/25/97 of 1 Burial 2 Cremetion 3 Removel from State Depertment of important: If any injury or once. = 5 Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Mem. Park 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Gary L. Kaufman Funeral Home at Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075 23e. Pert1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert feilure. List only one cause on each line. Approximate Intervel Betw **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) Dua to (or as a consequenca of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Undarlying Ceusa (Disaase or injury thet initietad evants resulting in daath) Lest and Dua to (or as e consequence of): Box 68760, that the death certificate be Physician/Medical the Dua to (or es e consequença of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? O ۵ 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ been signe should be Completed 24b. Were eutopsy findings eveilebia prior to 24e. Wes an eutopsy completion of cause of daeth? page 2 Yes 2□No 1 Yes 2 No of Vital director. Be 25. Wes case rafarrad to medical 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 X Yes 2 □ No 27. Manner of Daeth 28b. Time of 28a. Dete of Injury (Month, Day Yeer) 28c. injury et Work? 28d. Dascribe how injury occurred Division 5 Pending Investigation Attending 1 Divaturel Driver o) 0440 1 Yas 2 Ao 11.23-97 by the 1 2 Accident 3 Suicide 6 Could not be 28a. Placa of Injury - At homa, farm, streat, fectory, office building, atc. (Specify) City or To or A efter Direc 4 Homicide sell+Bayard St3 To the Hospital of within 24 hours of To the Funeral Completely filled 1 Cartifying Physician: To the bast of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) and manner as stated.

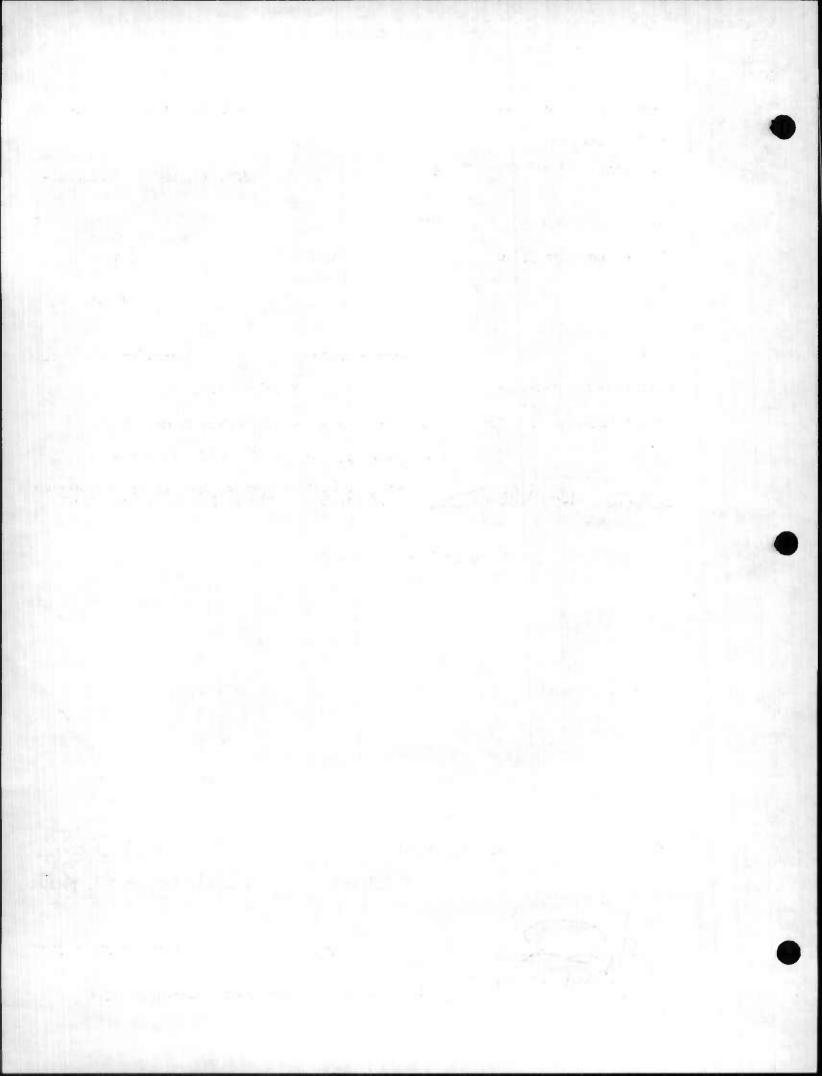
Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a. Cartifian Medical (Check only one) 29b. Signature and title of cortifier 29c. Licansa number 29d. Data signed (Month, Day, Yaer) OCME NOVEMBER 22, 1997

iated cause of deeth (item 23a) (Type, Print)

State Registrar 30. Neme and

NOV 2 5 1997

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Edison Month reng 1997 18 2300 November 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Sinai Hospital If Under 24 Hrs 8. Date of Birth (Month, Dey. 5. Sociel Security Number If Under 1 Year Birthplece (State or Foreign Country)
 NORTH CAROLINA 7. Age (In yrs. last birthdey) 1 M 2 F Days 88 Yrs. 243-16-1531 10/9/09 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 StYes 2 □ No N/A BALTIMORE 10e. Street end Number 10a. Citizen of Whet Country? 10f. Zip Code 740 POPLAR GROVE U . S . 14. Rece - American indien, Bleck, White, etc. 21217 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -0upholster FURNITURE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) HENRY TAFT LULA WASHINGTON 19e. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2414 ARUNAH AVE. -BALTO., ALMA EVANS (GRANDAUGHTER) MD 21216 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) AYDEN CEMETERY 11/24/97 AYDEN, NORTH CARD 21. Signeture of Funerei Service Licensee ELIZABETH L. PHILLIPS CFSY Obela 1721-27 N. MONROE ST.-BALTO., 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate intervel Between Onset end Death Immediate Ceuse (Finei Gastrointestinal 12 hours disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Due to (or es e consequenca of): Pert ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Applic Arev Rysm 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Anemia tia 1□ Yes 2No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No tinpatient 2□ ER/Outpatient 3□ DOA 28e. Date of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describa how injury occurred 5 Pending investigation 1 Naturel

Physician /Medical Examiner

Physician

/Medical

Examiner

10e State

MD

Funeral

Director

28a-f show

ò items 23a

"natural", or

permit. Pages 1 and 2 should be filed within 7; Department of Health end Mental Hygiena. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

the buriel-transit 88 signed by Medical Certification: To

Physician/Medical Examiner

ģ

Completed

Be

After this

Hospins or Attending Physician: The law requires that the death certificate be executed. P.O. Box 68760, Records, Division of Vital

To the Hospital within 24 hours To the Funeral C

State Registrar 29b. Signetyce end title of cartifier sowes VO

2 Accident 3 Suicide

4 Homicide

29a. Certifier

6 ☐ Could not be determined Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.

28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No Location (Street end Number or Rural Route Number, City or Town, Stete)

Baltimore, MD 21215

29c. License number

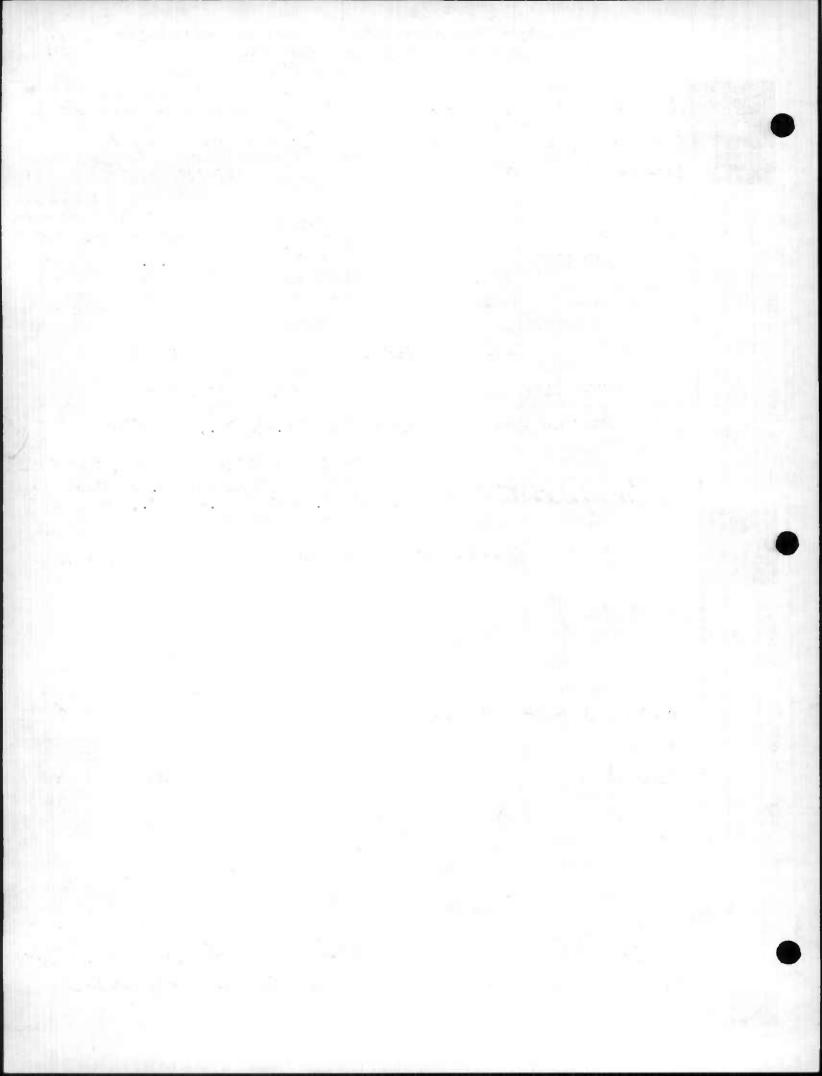
29d. Dete signed (Month, Dey, Year)

AS-2402321- JB-9338 November 18, 1997

30. Name end address of person who completed cause of deeth (item 23a) (Type, Print) R. Bowers, MD

2401 W. Belvedere Avenue Jamelle 31. Date filed (Month, Day, Year) NOV 2 6 1997 32. Registrer's Signeture

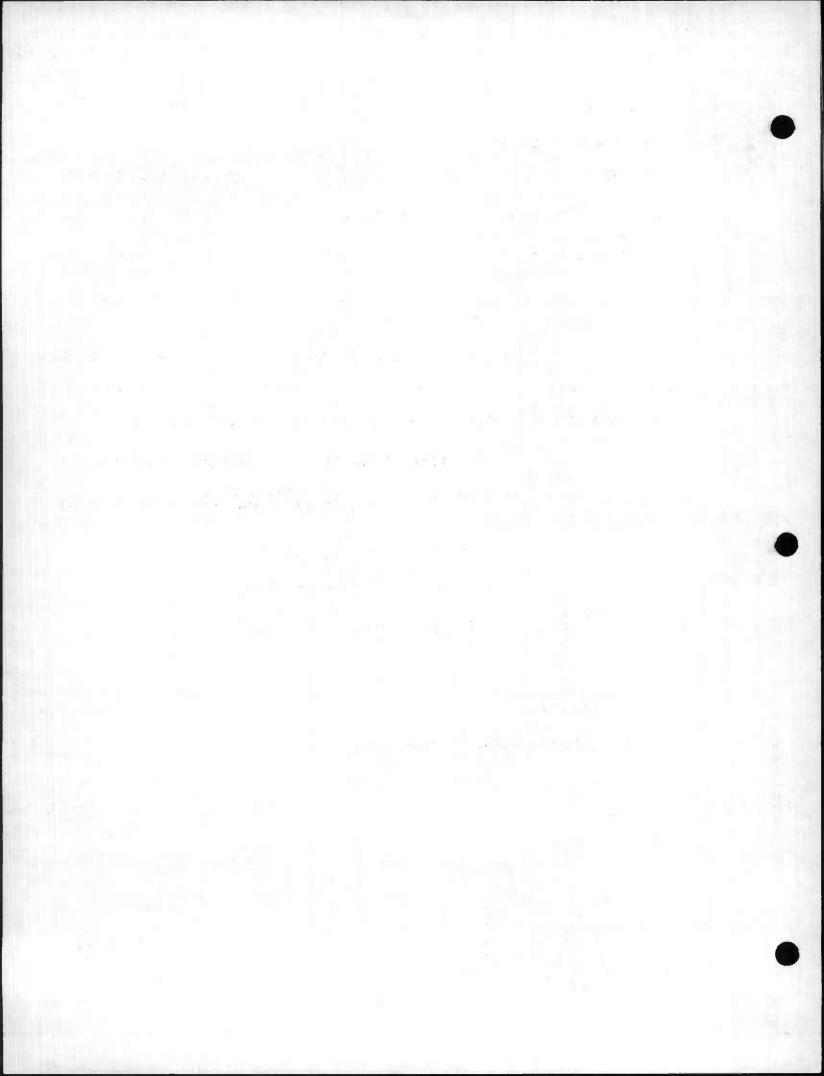
while widson-Randell



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** NOV" . 23 Day 1997 ear 10pm FRAHM ALFRED Τ. . /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE BALTIMORE SUNRISE ASSITED LIVING 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplece (Stete or Foreign Country) **Funeral** 10 M 20 F Days Yrs. Director 219-01-9458 82 15,1915 MARYLAND Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 3800 OLD COURT RD. 21208 USA Funeral 11. Marifal Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 72 hours after 1 Xes 2 No If Yes, Give Yeer or Dafes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic avant Elementery/Secondary (0-12) College (1-4or 5+) 5+ CHEMICAL ENGINEER DEPT. OF DEFENSE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be MAX ZELICK FRAHM YETTA ROSENBERG 0 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. SUSAN MODLIN (DAUG.) 3441 ROBINSON DR., OAKLAND, CA 94602 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/25/97 HEBREW YOUNG MEN BALTIMORE, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Sol Levinson & Bros., Inc. noon 8900 Reisterstown Road Pikesville, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw **Physician** /Medical Immediete Cause (Finel disease or condition resulting In deeth) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physiclan and Records, P.O. Box 68760, Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown by Multiplanet dementa 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed peeu has certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Livier Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 2 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) After this funerel 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of Injury 28d. Describe how Injury occurred or Attending P effer death. Director: After t Certification: 28c. Injury et Work? 5 Pending investigation 1 Naturei 1 Yes 2 No 2 Accident by the 3 SuicIde 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eff To the Funeral DI completely filled in 1th Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier 29b. Signature and fitte of certific 29c. License number 29d. Date signed (Month, Dey, Year) death (Item 23a) (Type, Print) NA 4000 1/162 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State NOV 26 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene 97

IAT	ARY FLO	IJυ					Ce	rtificate	e of	Death		TE-	Reg. N	0.		
П	Physic	ian	Decedent's Name (First, Min	ddle, Last)								2. Data of D		θу	Year	3. Time of Death
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J	Exami	ner	4e. Facility Name (If not institu	-								ocation of Dee	th 4	c. County	y of Death	
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	Funerai Director		5. Social Sacurity Number 213-52-2420 Usual Residence of Decedent	6. Sax	/ 2 X) F	7. Aga (In yrs. 55	lest birthday) Yrs.	Months Months	1 Yaar Days		Min.	8. Date of B (Month, L)			9. Birthi Coul	placa (Stete or Foraign ntry)
	/land		10a. State 10b. Cour	nty		10c. Ci	ty, Town or Lo	ocation								10d. Inside City Limits
	Man H sh	tor	Md.	NA		Ва	altimo	ore						M Yes 2□No		
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	deat	Funeral	11. Maritai Status	12	12. Was Decedent Evar in U,S. 13. Wa. Armed Forces?				ent of	Hispanic Or	ecify Yas or N Ricen, etc.)	lo-	cen Indian,			
5-0020	"natural", or items	by	1 □ Never Married 2√√√√ 3 □ Widowed 4 □ Divord		1 ☐ Yes : If Yes, Give Year or Da	2 No		1 Yes 2				nicen, etc.)		Specif	ack	
5-0	72 h netu	etec	15. Deced (Specify only hig	lent's Educa hast grade d		on 16e. Decedent's Usuai Oc mpleted) (Give kind of work do					at of work	ring	16b. l	Kind of B	usiness/In	dustry
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b	be filled with that Hygiene d other the	Be C	17. Father's Nema (First, Midd	le, Last)						18. Moth	er's Nam	e (First, Middl				
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altimore,	permit. Pages 1 and 1 Department of Health Important: If Item 27 I any Injury or other tr once.		Elizabeth W 20a. Mathod of Disposition 1 Buriai 2 Cramatio 4 Donation 5 Other	n 3 □Ren (Specity)	rare	ing Me	em. P	k.	Cem.	. 11	-28-9	7 1				
Ö	Deparimposition in position in		22. Nama and Address of Facility Baltimore, Maryland 2 WM.C. March FH 1101 E. North Avenu Wm. C. March as cardiac or respiratory arrest, Approximately a service Licensee Approximately a service Licensee Approximately a service Licensee WM.C. March FH 1101 E. North Avenu Approximately a service Licensee Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Approximately a service Licensee Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. March FH 1101 E. North Avenu Wm. C. Marc												nd 21202 venue	
	Physician /Medical		immadiate Cause (Final	or complica ist only one	tions that ca cause on ee	used the deat ch line.	h. Do not ent	er the mode	of dyi	ing, such as	cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
	Examiner		disease or condition resulting in deeth) a. Hypertensive Arteriosclerotic									ovascu	lar	Dise	ase	
		ē				Due to (d	or es a consec	quence of):								
o,	rificate be axecuted ng physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events	f b	b. — Due to (or as a consequence of):										1	
68760,	ate be nysici	edicai	that initiated events resulting in death) Last	C. =		Due to (o	r es a conseq	uance of):								
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ital Records,	law requiras las been signies e.2 should be	Completed b	ASTHMA									24a. Wa per INSP	formed?		ev co	/ere autopsy findings reliable prior to empiation of ceuse death?
2	ian: The law rtificata has l	Co										1	Yes 2	XXNo	18	☐ Yes 21 No
1	an: tiffica tor,	e	25. Was case referred to medi	cai						26. Place	of Deat	h (Check only	one)			

Division of V

Certification: To

stor: After this cer To the Hospital or Attending Physici within 24 hours after death.

To the Funeral Director: After this cer Medicai

1XX es 2□ No 27. Menner of Deeth 1 X Waturei

29a, Certifier

29b. Sigs

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 - Homicide

Laron Locke M.D.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year)

28b. Time of

Other: 4 Nursing Home 5XX Residence 6 Other (Specify) 28c. Injury at Work? 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

O.C.M.E

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

NOV. 24, 1997

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

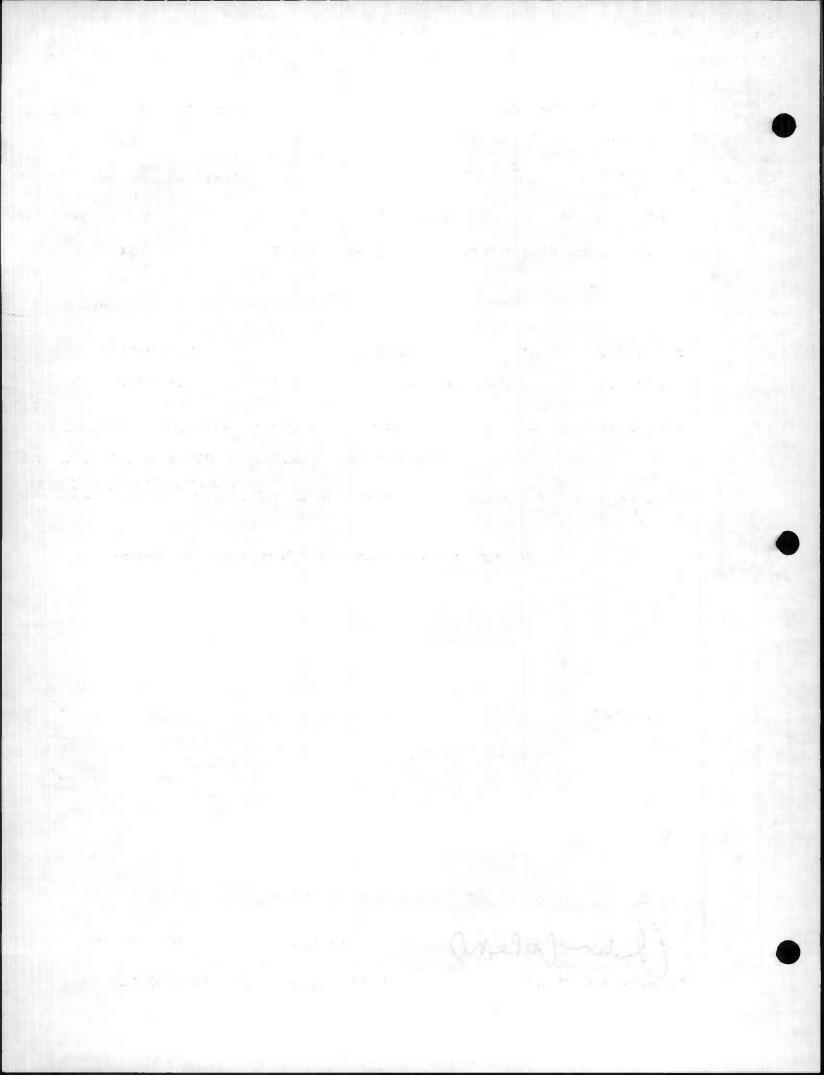
Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. Licansa number 29d. Date signed (Month, Day, Year)

d address of person who completed ceuse of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Dey, Year) NOV 26 199

32. Registrar's Gignature.



State of Maryland / Department of Health and Mental Hygiene 7

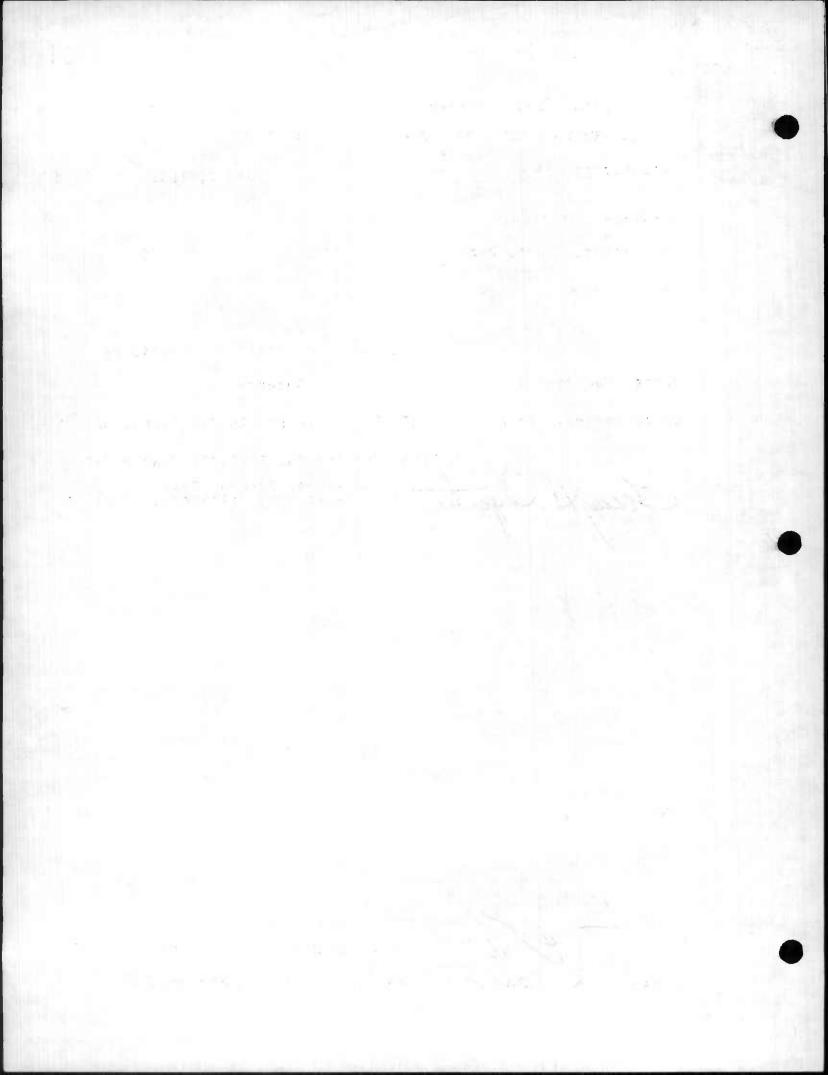
							Cert	tificate	of L	Death			Reg.	No.				
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and w		Usual Residence of Decedent 10e. State 10b. Cou	nty		10	c. City, Towr	or Loc	ation							1	Od Insid	e City Limits	
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E E		19a. tnformant'a Name/Relati	onship (7	ype, Print)		19b.	Meiling	Address (5	Street e	nd Numb	er or Rur	ral Route Num	ber, Cit	y or Town	, Stete, Zip	Code)		
item 27 other tr		MRS. MAXINE ROSENTHAL (DAUG.) 42 STIRRUP CT. BALTIMORE, No 20a. Method of Disposition 20b. Place of Disposition (Neme of Date 2																
0 - 2		XX Burial 2 □ Cremetion 3 □ Removal from Stete 4 □ Donetion 5 □ Other (Specify) Commetery, cremetory or other plece) HEBREW YOUNG MEN 11/26/97 BALTIME												MORE, MD				
Department Important: I any injury o		21. Signeture of Funeral Service Licensee 22. Name and Address of Facility BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.													LE, M	D 21	208	
		23a. Part1. Enter the disease shock, or heart failure. I	or comp	olications that o	caused the	death. Do r	ot ente	r the mode o	of dying	, such as	cardiac	or respiretory	arrest,			Approxi	mate Between	
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5	t	30. Name and address of pers	on who o	ompleted caus	se of deeth	(Item 23a) (Type, P	rint)	رب		^					1.1		
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State of Maryland / Department of Health and Mental Hygiene O

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Л	/Media		4a. Facility Nama (If not institution, give straat and numbar)	4b. City, Town, or Lo		22, 199 4c. County		0817_AM
4	Examir	ier	30 EAST PRESTON STREET 3RD FLOOR	BALTIMO		N/A		
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	th wil	a je	4202 Prince George Road	21216		US	Α	
020	n 72 hours efter death with the Maryland "netural", or items 23s or 28s-f show edical Examiner must be notified at	by Funeral	1 🔀 Navar Married 2 🗌 Marriad 1 🗌 Yas 2 😿 No	of Hispenic Origin? (Spe Cuban, Maxican, Puarto I No Specify:	ecify Yas or No- Rican, atc.)	Blec	a - America k, Whita, a Whi	itc.
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	d 2 s		Bruce Godfrey Father 4202 Print			-		
Baltimore,	f Health item 27 other tr		20a. Mathod of Disposition 20b. Placa of Disposition (Nama of	of deorge		20c. Location -		
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	death he etten ed for u	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the undarlying caus-	a givan In Part I.	23b. Did tol	bacco use cor	ntribute to	the cause of death?
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	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edlcai (29a. Certifiar (Check only one) 1 Certifying Physician: To the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the best of my knowladge, death occurred at the control of the control of the control of the best of my knowladge, death occurred at the control of the control	a tima, data and placa, a ny opinion, death occurre	and dua to the ca	use(s) and ma	nnar as sta	atad. the cause(s)
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			9/9/	.C.M.E		NOV.	22, 1	.997
1	2		30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print)					-10
			David R Fouler 111 Penn Street	t, Baltimor	e, Mary	land 21	201	
	Sta Registr	_	31. Data filad (Month, Day, Year) 99. Registrar's Signature NOV 2, 6 1997					
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State of

35862

f Maryland / Department of Hea	th and Mental Hygiene 7	8
Certificate of De	ath _	d

Physician /Medical Examiner
Funeral

Director show 28a-f must be notify 8 items 23a

Funeral 21215-0020 "natural", or by Completed event, the Medical Hygiena. marked other Baltimore, Maryland h and Mantal h Department of Health ar Important: If item 27 is any injury or other trau Physician /Medical Examiner Examiner pue Box 68760 90 Physician/Medical for use as 0 3 0 bened b Records, by Completed pege 2 entificete Vital Be 2 of Certification: Division after Olrec To the Hospital o within 24 hours af To the Funeral DI completaly filled in Medical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYAMAN 31. Date filed (Month, Day, Year) NOV 2 6 1997 State Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Denver Karl Green NOVEMBER 20, 1997 5:35 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth ANKE 4342 6th.ST. HRUNDEI, MA BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 10 M 2□ F 214-96-6077 24 Yrs. Jan. 17, 1973 Md. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. n/a Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 704 Deacon Hill Ct. 21225 USA 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X of Yes, Give Specify: Black 1 ☐ Yes 2XXX0 Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade unemployed n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James W. Green Jr. Wilhelmenia Wilkes 19a. Informant's Name/Relationship (Type, Print) father 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Green Jr. 704 Deacon Hill Ct. Baltimore, Md. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State Arbutus Memorial Park Nov. 28 Baltimore, Md. Donation 5 Other (Specify) 21. Signature of Funeral Servica Light 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part 1. Enter the disease, or complications thus shock, or heart failure. List only one cause of Err death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final SUNSHOT WOUND OF HODD disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 18 Yes 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) WOODS 1XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending Injury Surster S HOT 17368 1 Yes 2 No FOUND 11-20-07 investigation 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 4342 6th STAME ARUPACOMO FOUND IN WOODS 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

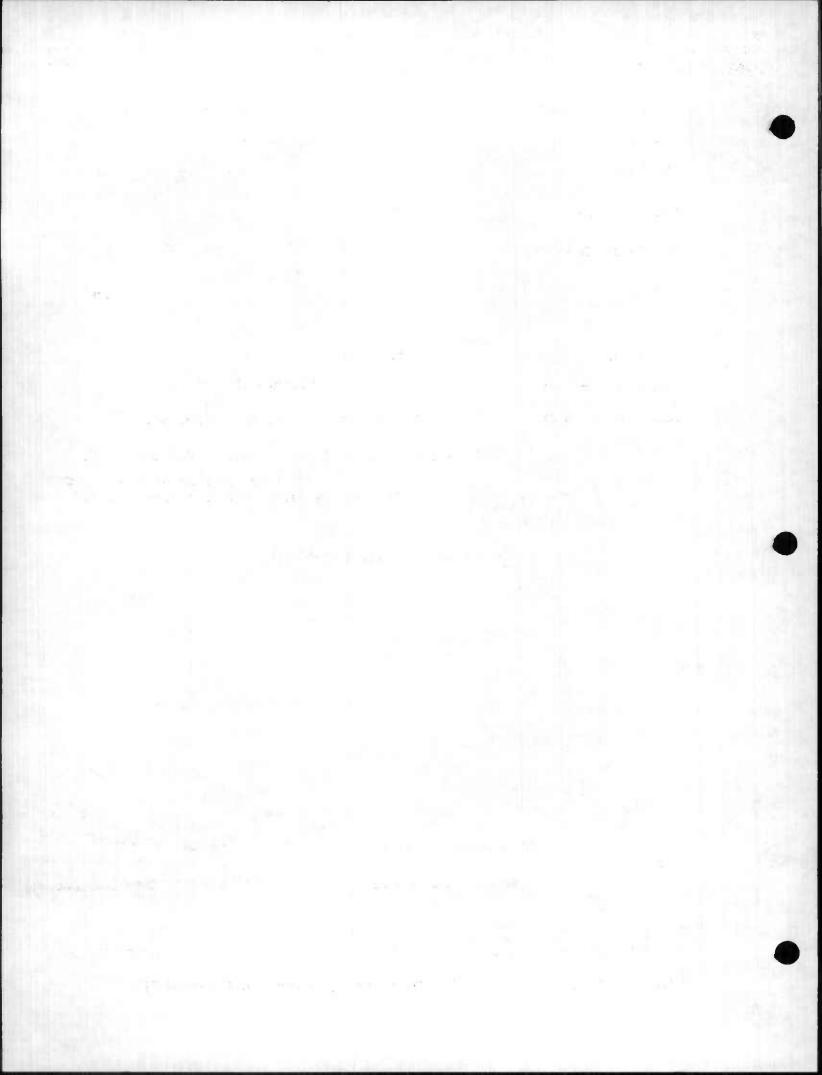
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month, Day, Year)

OCME

Penn Street, Baltimore, Maryland 21201

82 Registrate Stonetta

NOVEMBER 21, 1997



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 4 Oxmes MARIA **GELBSHTEYN** 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death HOSPICE OF BALTO. - GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 7, 1912 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min 1□M 2₽F 215-96-6442 Yrs. RUSSIA Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1☐Yes 2☐No BALTIMORE OWINGS MILLS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2305 VELVET RIDGE DR. USA 21117 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No It Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian. 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) CHEMIST CHEMICAL 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) **GELBSHTEYN** SARA LEE ZELENTSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) MRS. GALINA RAGIMZADE (DAUG.) 2305 VELVET RIDGE DR. OWINGS MILLS, MD 21117 20c. Location - City or Town, Stata 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Data 1 Burial 2 Cremation 3 Removal from Stata BALTIMORE HEBREW 11/19/1997 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 22SOL: LEVINSON BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, cause on each line. Onset and Death immediata Causa (Final disease or condition resulting in death) · Strang renal 9 years Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

permit. Peges 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trait

Physician

/Medical

Examiner

10e. State

Director

Funeral

20

Completed

Funeral

Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at

2 should be filled within 72 hours after and Mental Hygiena. Is marked other than "natural", or its

Saltimore, Maryland 21215-0020

Division of Vital Records, P.O.

cartificata has

funeral

or Attending Physician: efter deeth. Director: After this cartific

To the Hospital o within 24 hours of To the Funeral D

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated events resulting in death) Last Physician/Medical 950

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Completed

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Certification:

edical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

24b. Ware autopsy tindings available prior to completion of cause of death?

26. Piace of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case raterred to medical axaminer? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work?

32. Registrar's Signature

28a. Date of Injury (Month, Day Year) 27. Mannar of Death 1 DeNatural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Julia Davidson-Rindall

1 ☐ Yes 2 ☐ No 281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year)

YOW

4 Homicida

1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and fitte

2 6 1997

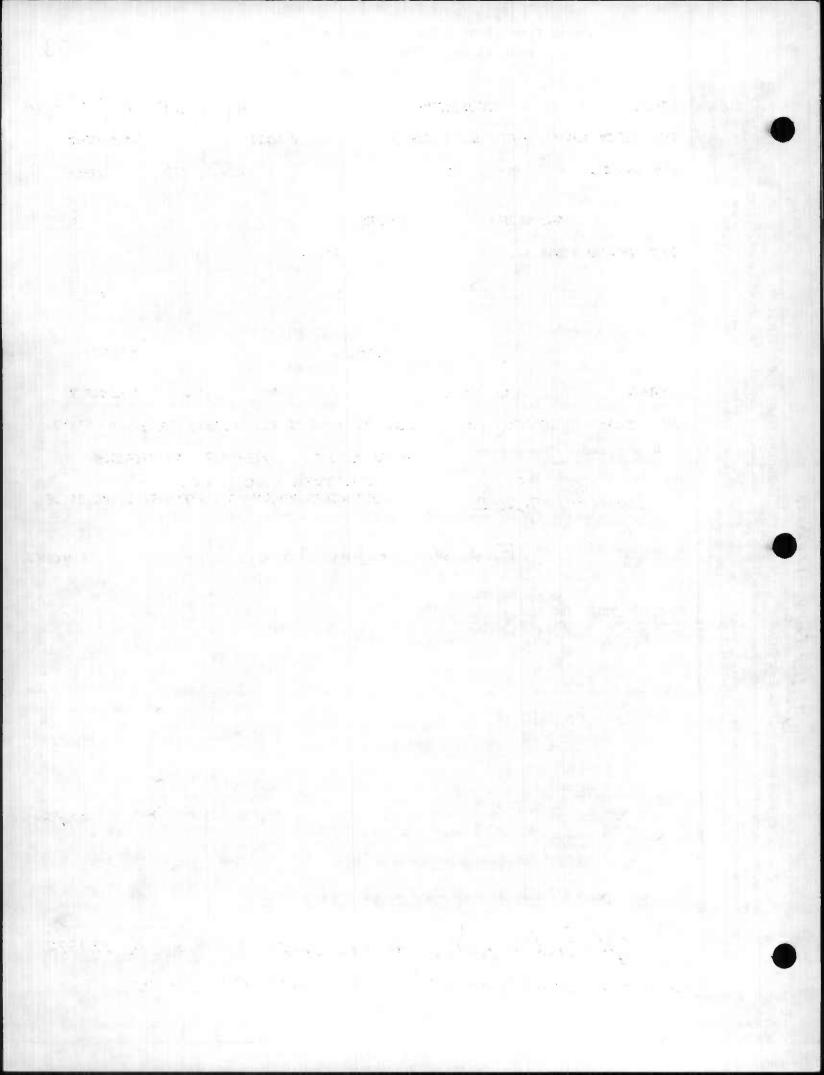
29c. License number

29d. Date signed (Month, Day, Year) November 17, 1997

30. Nama and addrass of person who complete duse of death (Ijom 23a) (Type, Print) GBMC W. A. Riley

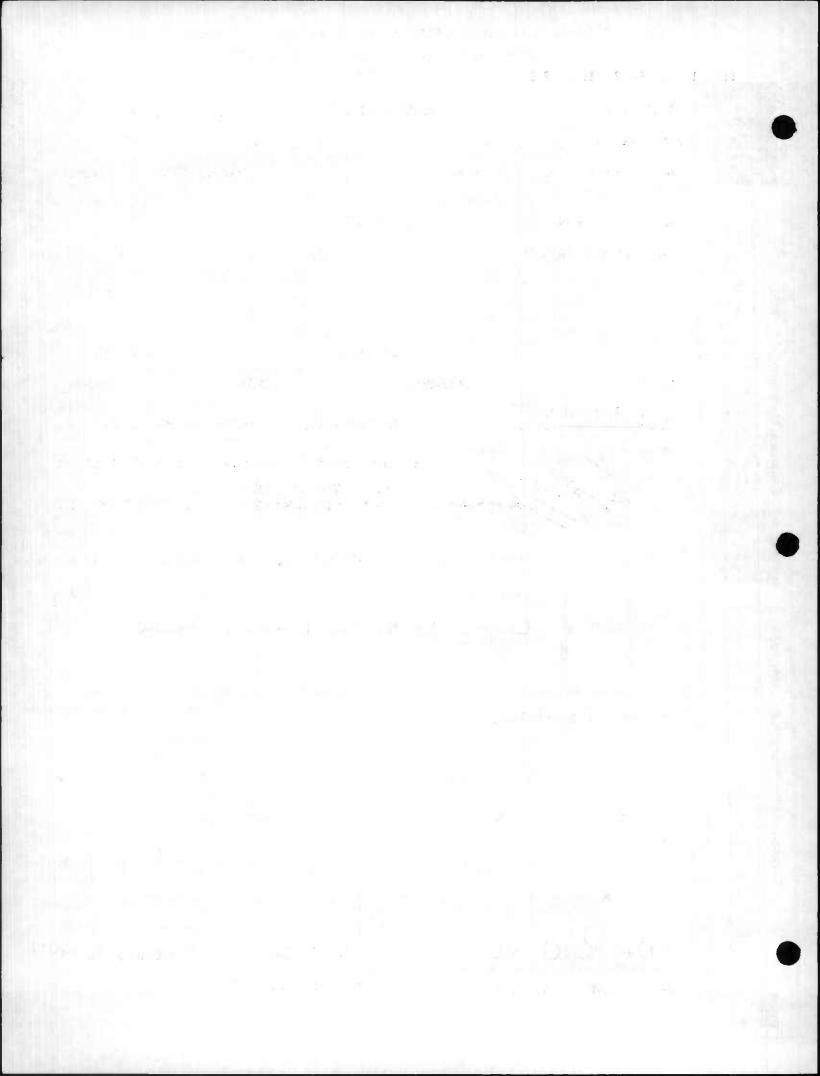
Balto. Md. 21204

Registrar



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		9a per FH G753 11/2 1. Decedent's Name (First, Midd			Ochun	icate of	Death	2. Dete of De		3. Time of Death	
Physic /Medi	cal	VICTOR			GOLDI			NOVEMBE		97 11:15 A	
Exami	ner	4e. Fecility Name (If not institution THE JOHNS HOPK	The second second second				BALTIMOR	r Location of Deeth		/A	
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show		10a. State 10b. Count	у	10c. City,	Town or Location	n				10d. Inside City Limit	
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ours after dea rail, or items Examiner ma	by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give	□No	er in U,S. 13. Wes Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto I 1 Yes No Specify:				ecity Yes or No- Rican, etc.) 14. Race - Americ Bleck, White, Specify: WF		
filed within 72 hours after Hygiene. ther than "natural", or he ont, the Medical Examine	Completed	15. Decede (Specify only higher Elementary/Secondery (0-12)	nt's Education ast grade completed) Coilege (1-4c	or 5+)	life. DO N	s Usual Occup of work done IOT use retired	during most of we	orking	16b. Kind of Business/Industry PAWNBROKER		
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4430		19a. informant's Name/Relation Robert Goldberg (Rural Route Number			
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		Burial 2 Cremation 4 Donation 5 Other (te	HAR SIN			/21/97	OWINGS	MILLS, MD	
permit. Pag Department Important: It any injury o		21. Signature of Editoral Service	tioeneee			me and Addre		ROS., IN			
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und und und und und und und und und und	Examiner	Sequentially list conditions,	b. Sepsi	S Due to (or e	es e consequenc	a of):				day	
ng physiclan as the bundle	edical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Chron		Obstru as e consequenc		Pulmoi	nary [isease		
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by the at	ysici	Part II. Other significant conditi	ona contributing to death	but not result	ting In the underl	ylng cause giv	en In Pert I.	23b. Did 1	obecco usa con	tribute to the cause of death	
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yacıarı. is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 TE	R/Outpatient 3	□ DOA Oth	or	eath <i>(Check only o</i> Home 5 Resid		(Spanihi)	
After th	atlon: T	27. Manner of Death 1. Netural 5 Pendi 2 Accident Invest	28a. Date of Ir (Month, L		28b. Time of Injury	28c. Injur Wor		7	now injury occurre		
within 24 hours after deat To the Funeral Director: completely filled in by the	edical Certification;	3 Suicide 6 Could 4 Homlcide determ	nined 289. Pieca of	Injury - At horr etc. (Specify)	ne, ferm, street, f	actory, office		28f. Location (5 City or Tox	Street and Number on, Stete)	r or Rural Route Number,	
24 hour	dical	29a. Certifier 1 Certifying (Check only one)	ng Physician: To the bes Examiner: On the besis and menner	of exeminatio	edge, deeth occ on end/or investig	urred at the time petion, in my o	ne, date end piec pinion, death occ	e, and due to the curred at the time,	cause(s) and mer dete and piece, a	ner as stated. nd due to the cause(s)	
within To the	Me	29b. Signature and title of sertific		Stateo.		29c. Licens	e number		29d. Date signed	(Month, Day, Year)	
		Dreg You	ell MO			RE	5-000	0	Novemb	er 18,1997	
2		30. Name and address of person			_)				0.4 1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Yaa SSE E HOOC 2:50 A 97 4a. Facility Nama (If not institution, giva street and jumber) 4b. City, Town, or Location of Death 4c. County of Death Undar 24 Hrs. 5. Social Sacurity Number 6. Sax yrs. last birthday) 8. Data 9. Birthplaca (Stata or Foraign Days 10 M 20 F Usual Rasidance of Dacedant 10b. County 10c. City, Ty 10d. Inside City Limits 1 Yas 2 No 10e. Street and Number 10g. Citizen of What Country? Was Dacedant Evar in U,S. Armed Forcas? 1 Yas 2 No/943 If Yas, Giva Yaar or Datas: 14. Race - Amarican Black, Whita, etc. 13. Was Decedant If Yas, specify (lispanic Origin? (Specify Yas or No-an, Maxican, Puarto Rican, atc.) Amarican Indian 11. Marital Status 1 ☐ Navar Marriad 2 12 Married 2 1 No 1 Yas Specify: 3 Widowad 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. PO NOT use ratingd) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla 100 19a. Informant's Name/Ralationship 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, IMORE, MO21229 20a. Method of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place, Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Coonse 23a. Part1. Enter the disease, or complications that excised shock, or heart failure. List only one cause on each line. leath. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximate Intarval Between Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No

Physician /Medicai Examiner

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After this certificate hes

director,

funeral

completely filled in by

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica

To the within 2

Completed

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Certification:

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Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f ahow traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event.

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

The law requires that the death certificate be

death with the Maryland

/Medical

10a Stata

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by Funeral

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Examiner Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Physician/Medical þ

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of cause of death?

20 No 1 Yas

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25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Mannar of Death Natural

2 Accidant 3 Sulcida

4 Homicide

29a. Cartifian

5 Panding Invastigation 6 Could not be 28a. Data of Injury (Month, Day Year)

28b. Tima of

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

28c. Injury at Work? 1 🗆 Yas 2 No 28d. Dascribe how injury occurred

1 🗹 Certifying Phyalcian: To tha bast of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as statad. 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29b. Signatura and titla of cartifiar

29c. Licansa number

29d. Data signed (Month, Day, Year)

30. Nama and addrass of pe no complated causa of daath (Itam 23a) (Type, Print)

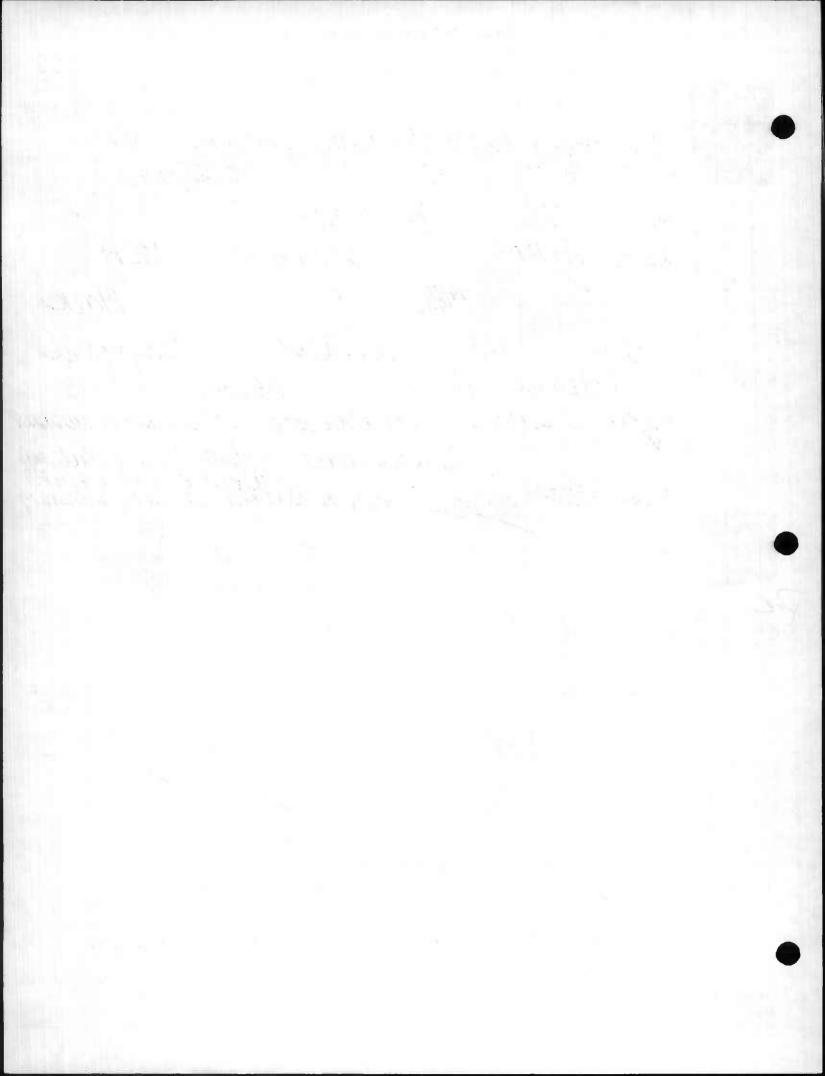
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f Ballimore MD 21201

State Registrar 31. Data filed (Month, Day, Year)

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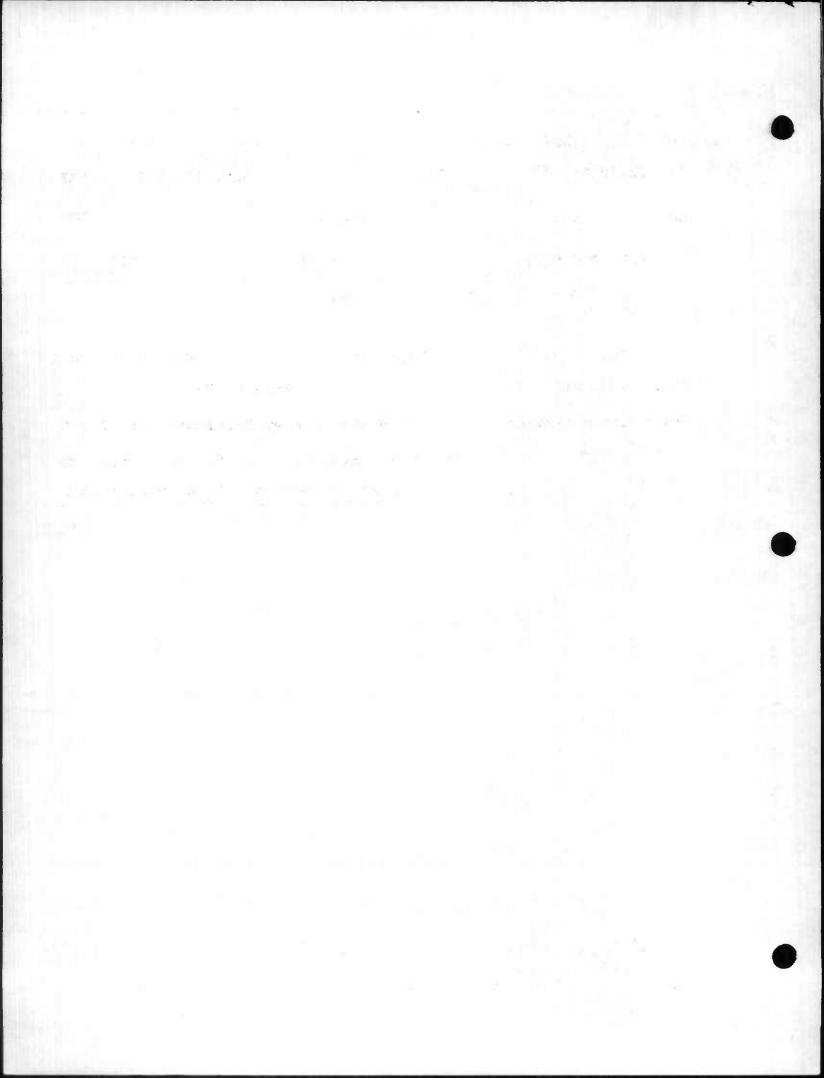
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 9 7

Certificate of Death 1. Decedent's Neme (First, Middia, Last) 2. Dete of Deeth 3. Time of Death Month Physician Hill Novem 0639 harles 25 1997 /Medical 4b. City, Town, or Location of Deeth 4a. Fecllity Neme (If not institution, give street end number) 4c. County of Deeth Examiner Northwest Hospital Center Randallstown Baltmore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) XXM 20F 213-07-8961 Yrs. 86 Director Aug. VA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at MD XXYes 2 □ No n/a Director Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 701 Wildwood Pkwy. Funeral 21229 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ Yo If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2000 Specify: Specify: Blk þ 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", any Injury or other traumatic event, the Medical Exer 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working iffe. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5th Engineer Bethlehem Steel 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles H. Hill, Sr. Rosa D. Ward 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Helen Mae Hill/wife 701 Wildwood Pkwy Baltimore, MD 21229 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stets Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) Mt. Zion Cemetery 11/29 Baltimore, MD Attinative of Funeral Service Li 22. Name end Address of Fecility James A. Morton & Sons Funeral Home 1701 Laurens St. Baltimore, MD 23a. Part onter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, should be heart feilure. List only one cause on each line. Approximete IntervsI Between Onset and Deeth **Physician** /Medical Immediate Cause (Final encephalopathy disease or condition resulting in deeth) Examiner bunai-transit Sequentielly list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Box 68760, attending physician for usa as the buria Physician/Medical P.O. P signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobseco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown Records. à 24b. Were eutopsy findings svaileble prior to completion of cause of deeth? 24s. Wss en autopsy performed? Completed page 2 1 ☐ Yes 2 Z No cartificata 1 ☐ Yss 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director; to 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 2 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigetion 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and plece, end due to the ceuse(s) end menner stated. 29e. Certifier (Check only 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D Roggen
31. Dste filed (Month, Dey, Year) Old Court Road 5401 Randallstown MO 32 Registrar's Signature State NOV 26 1997 Devideon Ro Registrar

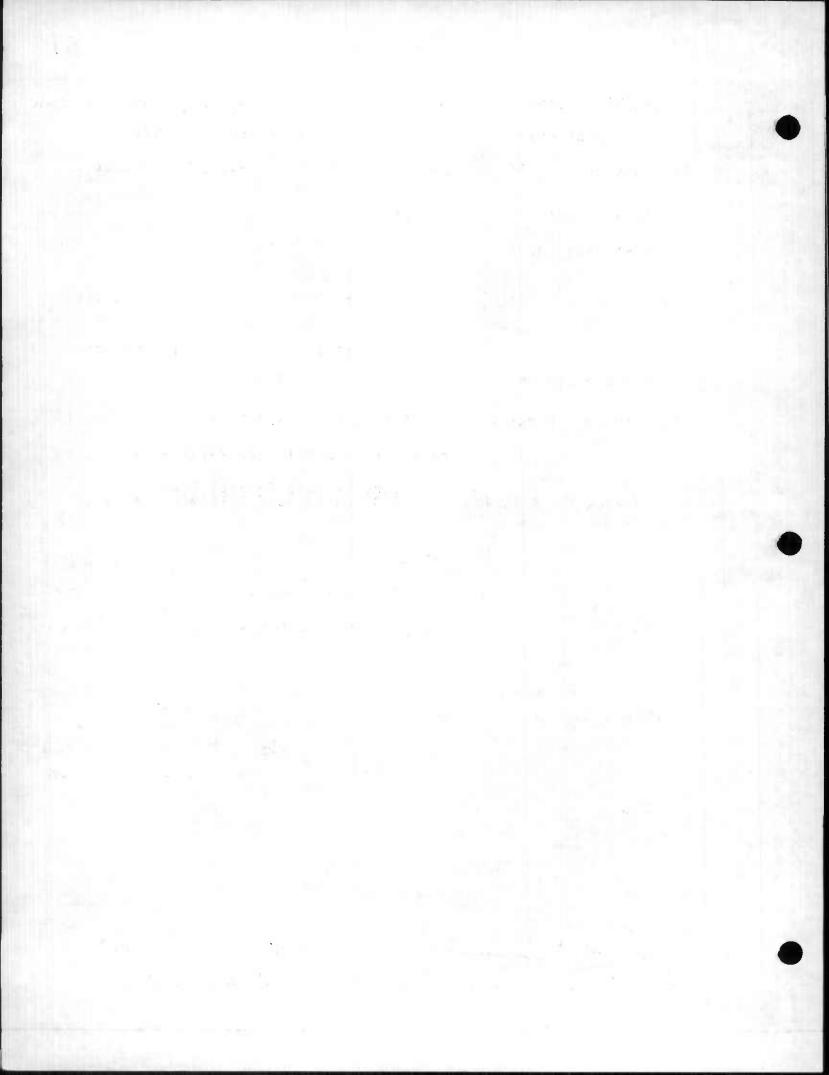


Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Day 1997 Year Month **Physician** 21, Reethia Hooker 4:00pm Nov. /Medicai 4a. Facility Neme (If not institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** 1434 Milrace Road Baltimore | Min. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) 9. Birthptace (State or Foreign **Funeral** 1 M XXF Deys 219-76-5314 87 Yrs. Director Usuet Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medical Examiner must be notified at XXYes 2 No Maryland N/A Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21211 USA 1434 Milrace Road Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic avent, the Medical Examena-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ XIo Specify: þ white 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuet Occupetion 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Cotlege (1-4or 5+) Etementery/Secondary (0-12) Housewife In Own Home 17. Fether's Neme (First, Middle, Last)
Sherman Lawson 18. Mother's Neme (First, Middle, Maiden Surneme) Be Nancy 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Cleo Warren Daughter 1434 Milrace Road Baltimore, MD 21211 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ♥ Burlet 2 □ Cremetion 3 □ Removal from State CrestLawn Memorial 11/24/97 Eldersburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Life 22. Neme end Address of Fecility Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD Stales 21211 enelle 23e. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximete Intervet Between Onset end Deeth **Physician** /Medical tmmediate Ceuse (Final diseese or condition resulting in deeth) Examiner Vascular physician and the bunal-transit Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): Coronar Box 68760, Artery Physician/Medical Due to (or as a consequence of): P.O. Pert tl. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 25 No 3 Probably 4 Unknown HTN, dementia, COPD Records, p 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? peen page 1 Yes 2 No 1 Tyes 2 No certificate. Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, 25. Wes case referred to medicat Be 26. Plece of Deeth (Check only one) Hospitat 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how trijury occurred 28c. tnjury at Work? Certification: 5 Pending investigation 1 Neturet 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 5 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

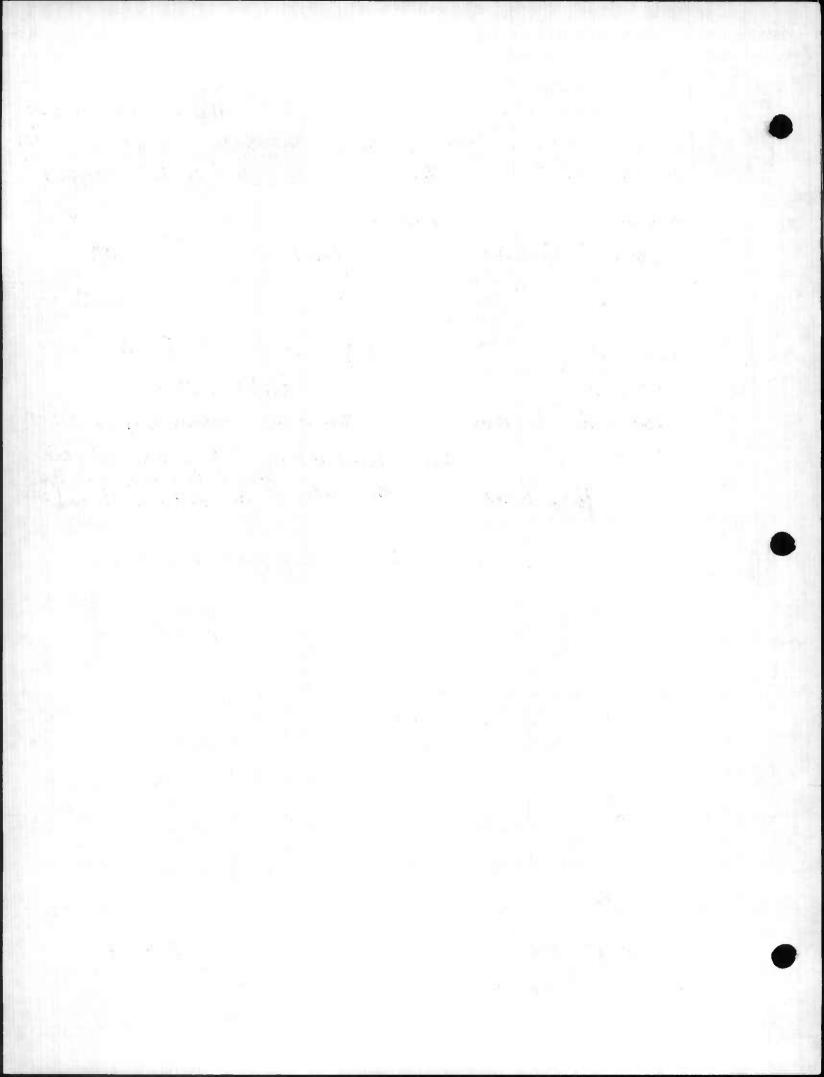
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, end due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and little of cartifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) E. Univ. Pkwy, Bult, MD 21218 Robert MCKINNEY Do 201 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature State Davidson Registra NOV 2.6 1997

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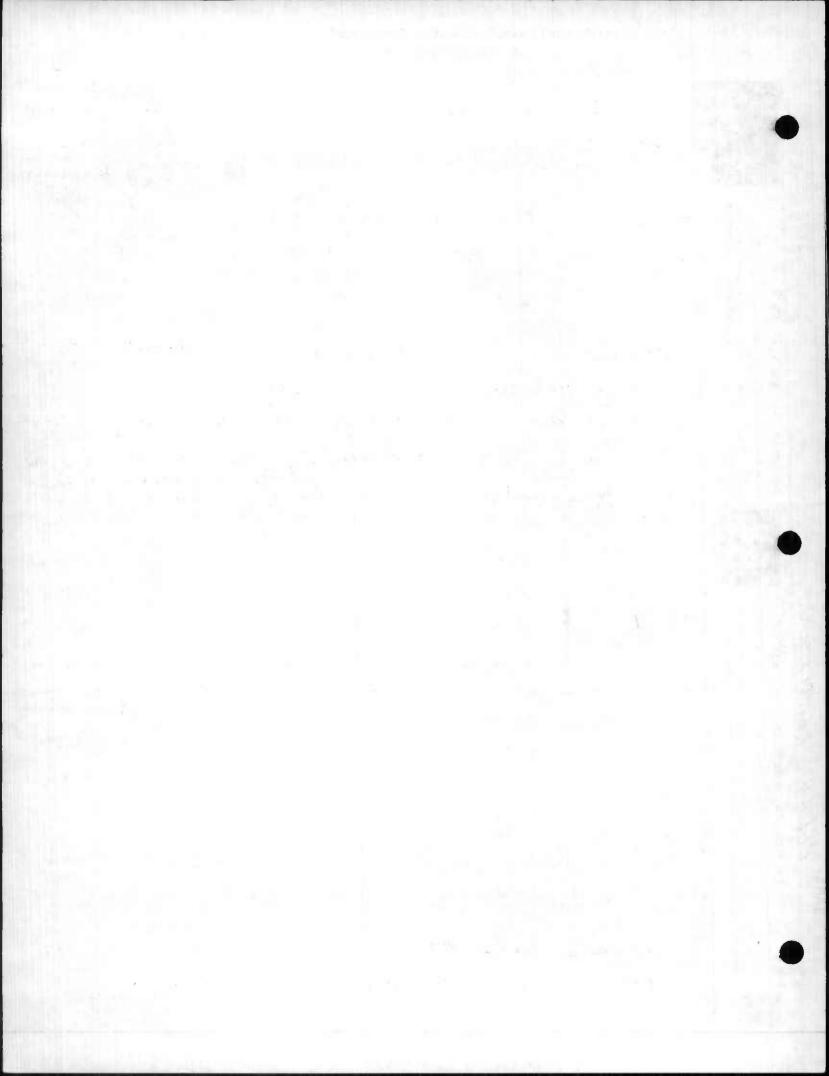
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State		30. Nama and addrass of person who comp Dor. R. K. Wali, E. A. 31. Data filed (Month, Day, Year)		m 23a) (Type, Pr ual Ce etura	ater,	Ballim	we					



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Health tem 27 other tr	20	9a. Intorment's Name/Relationship (1 Miland Wichol Da. Method of Disposition	Type, Print)				Eya	no (i moi, imoone,	manuali Caman	,	
Health tem 27 other tr	20	Mildred Wichols Da. Method of Disposition			19b. Mailing A	ddress (Straat	and Number or Ru	ıral Routa Numbe	er. City or Town.	Stata, Zip Code	a)
mit. Peges 1 a pertment of Hecocramt: If item y injury or other 29.			101-1-1	ind		4	ho Rd.	Baltim			2124
Pertr.	2	4 Donation 5 Other (Specify		te ce	iaca of Disposition ematary, cramato	on (Name of ory or other pla	ca)	Date 11/29	20c. Location -		
88 5 8 8		1. Signature of Funeral Service Licen	Parker		22. Na	ame and Addre	ess of Famility Re		arker F	uneral	Home
Physician	2	3a. Part1. Entar the disease, or comp shock, or heart tailure. List only	olications that caus one cause on each	sed the death	a. Do not enter th	ne mode ot dyi	ng, such as cardiac	or raspiratory ar	Baltimer rest.	Appl	roximata val Between et and Death
/Medical Examiner	di	nmediata Causa (Finai isease or condition	Dehu	dratio)/L					5-	10 day
	3	asulting in death)		Dua to (or	r as a consequen	nce of):					5
executed in end ial-transit			b. Hyper		emia					5-1	o day.
be executed ician end burial-transit	S	equentially list conditions, any, leading to immediate	44 /		as a consaquan	ice ot):					
sician buria		equentially list conditions, any, leading to immediate ause. Enter Undarlying ause (Disaasa or injury nat initiated evants	c. Malni		101					MO	onthy
ng physicia as the bu	la La	asuiting in death) Last	1	·	as a consequence	•					
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death e atte	Pe	art II. Other significant conditions co	ontributing to death	but not rasu	uiting In the under	rtving cause of	ven in Part i.	23b. Dld 1	obacco uss cor	ntribute to the	causs of dea
signed by the attendir d be detached for use						,,,,,		10	Yes 2 No	3 Probably	4□Unkno
sw requires been 2 should		hypertens	on						an autopsy med?	available	utopsy tinding e prior to tion of cause 1?
The la	5							101	as 200 No	1 ☐ Yes	200 No
ysician: The is certificate director, pag		5. Was case referred to medical axaminer?						ath (Check only o	na)		
Physic all dire		ILI TAS ZUE NO	Hospital:		· · · · · · · · · · · · · · · · · · ·	3 DOA Ott	4 Li Nursing H	lome 5 Resid			
th. After a funera	2/	7. Mannar of Death 1. Naturai 5 ☐ Pending 2 ☐ Accidant Investigation	28a. Date of In (Month, D	Day Year)	28b. Time of Injury	28c. Inju Wo M 1 □	ryat rk? Yas 2∐No	28d. Dascribe t	now injury occurr	red	
To the Hospital or Attending Phywithin 24 hours effect death. To the Funeral Director: After this completely filled in by the funeral Completely filled in Certification: 1		3 Suicide 6 Could not be determined	28a. Place of li building, o	Injury - At ho etc. (Specify	me, farm, street,	factory, office		28f. Location (S City or Tox	Street and Numb in, Stata)	er or Rural Rou	ta Number,
Ne Hospita n 24 hours Ne Funeral pletely fille		9a. Cartifier 1 Certifying Phy (Check only one)	yaician: To the bas linar: On the basis and manner:	of axaminati	viadga, daath occion and/or investi	curred at tha tili igation, in my d	ma, date and place opinion, daath occu	, and due to the orred at tha time,	cause(s) and ma data and place, a	inner as stated. and due to the o	cause(s)
Me Within		b. Signature and title of certitier	0.			29c. Licens			29d. Date signed		
		1 Stanhania	Lindo-	MI	1	14	3909		1h. Jouch	- 23	1997
	30). Name and address of person who o	completed causa of	daath (Item	23a) (Type, Prin	nt)	3909 Baltin		veme		((//
		Stephanie Lin	der 5	7. Ag	ques Hos	spital	Baltin	rore, M	aryland	1	
State Registrar		Date tiled (Month, Day, Year)		strar's Signat	tura 📞				1		

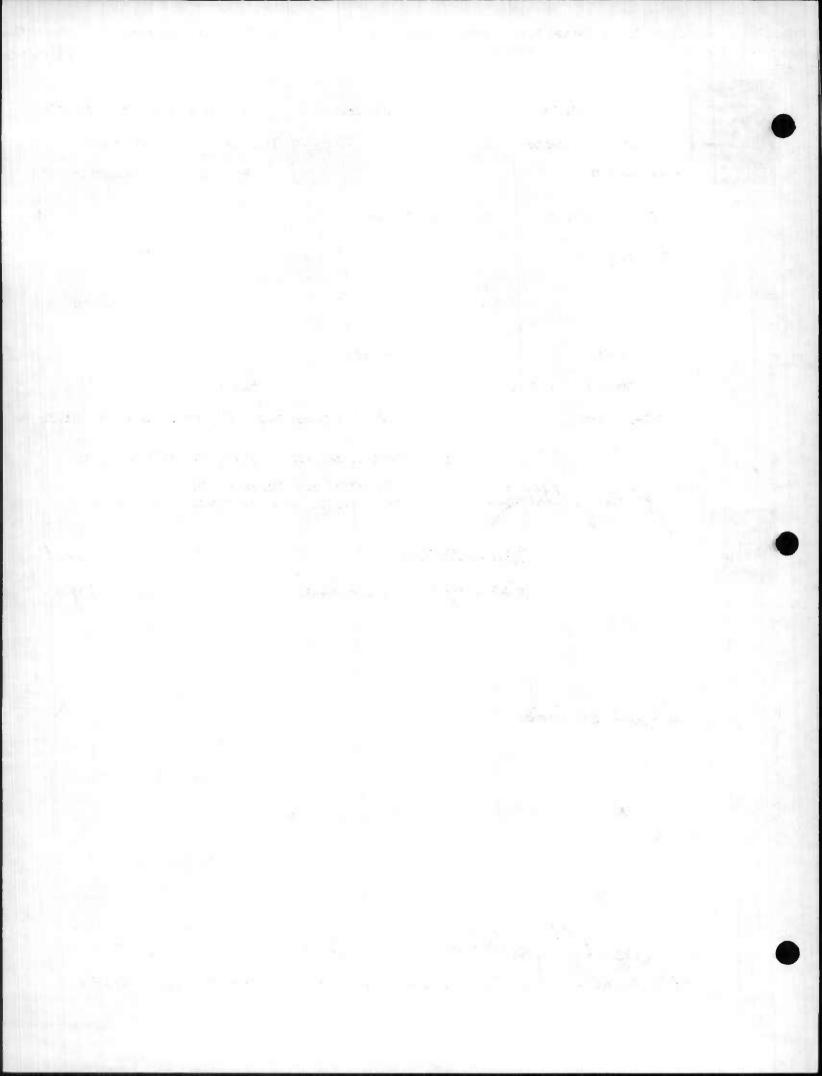


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time f = th Month Physician November 19, 1997 11:45 M WILLIAM **JACKSON** /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Loch Raven Center Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1**X** M 2□ F Deys Yrs. Director 406-09-9228 87 Apr. 2, 1910 Kentucky Usuel Residence of Deceden the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show ofices Examiner must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21234 8720 Emge Rd. USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 11. Maritel Stetus 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours efter 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 X No Specify: þ 3 ₩idowed 4 Divorced Specify White Completed 15. Decedent's Education (Specify only highest grede completed) the Medical 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Unknown Laborer Self Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health end Mental (unknown) Jackson May Saxton 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) or other tra Helen Vinci 17 Juliet Lane, Unit 204, Baltimore, MD 21236 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlel 2 【Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: if any injury or Green Mount Crematory 11/22/97 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214 Nenter the disease, or complications than caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximate Intervel Betw Onset end Deeth **Physician** /Medical Immediete Ceuse (Final Malnutrition disease or condition resulting in deeth) **Examiner** Examiner Sequentielly list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Box 68760, physician Physician/Medicai Due to (or as a consequence of): The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed pege 2 should be de Records, Completed by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? 2 No this certificate 1 Tes 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: director, Be 25. Wes case referred to medical 28. Plece of Deeth (Check only one) Hospitel: 1 | Inpetient 2 | ER/Outpetient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homicide 24 hours e 1 certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner stated. 29e. Certifier Medical stely i within 2 To the To the 29b. Signeture end title of certifie CARL 29c. License number 29d. Date signed (Month, Day, Year) SPERLING D28987 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) BALTO. MD. CARL SPERLING, M.D. 5601 LOCH RAVEN BLUD 31. Dete filed (Month, Day, Year) 32. Registraria State

Registrar

NOV 26 1997



State of Maryland /

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1	J	J	0	1	

Department of Health and Me	ental Hygiene 9 7	3	5	8	7
Certificate of Death	Dee No	0			
Continuate of Doutin	Reg. No.				

Physician /Medical **Examiner**

Leroy J. Jackson

Days

2. Date of Death OCTOBER D27, 1997 3. Time of Death 21:56 PM

4a. Facility Nama (If not institution, giva street and number) 1424 ALBERTA DRIVE

5. Social Security Number

4b. City, Town, or Location of Death DROTTI

4c. County of Deeth PRINCE GEORGES

Funerai Director

Itams 23a or 28a-f ahow

Director

Funerai

þ

Completed

Be

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traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death with t Department of Heelin hand Mental Hygiene.

Department of Heelin hand Mental Hygiene.

Department of Heelin and 18 merked other than "natural", or flams 23a or any injury or other traumatic event, its Mental Enumer mental or any injury or other traumatic event, its Mental and Institute mental or any injury or other traumatic event, its Mental and Institute Mental and Institute Mental And Institut

Physician

/Medical

Examiner

buriel-transi

physician a

and

Baltimore, Maryland 21215-0020

the Maryland

579-74-6636 Usual Residence of Decedant 10b. County

If Under 1 Months Yes. 40 10c. City, Town or Location

if Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, 11/23/56

 Birthplaca (State or Foreign Country) Wash.D.C.

10d. fnsida City Llmits

10a, Stata

MD P.G.

L□ Yas 2□ No

10e Street and Number

Forestville 10f. Zip Coda

7. Aga (In yrs. last birthday)

10g. Citizan of What Country? 4.S.A

1424 Alberta Drive 11. Maritai Status 1 Navar Married 2 Marriad

12. Was Dacedant Evar in U.S. Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:

20747 13. Was Dacedant of Hispanic Orlgin? (Spacify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.)

14. Raca - Amarican Indian, Black, Whita, atc.

3 ☐ Widowed 4 ☐ Divorced

15. Dacedant's Education (Specify only highast grada complated)

1₽M 2□F

18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)

1 Vas 2 No Specify:

Specify: Black 16b. Kind of Businass/Industry

Elementery/Secondary (0-12) 12

Collega (1-4or 5+)

mechanic

Private

17. Fathar's Nama (First, Middla, Last)

Robert Edward Jackson

Francis

19e. Informant's Name/Ratationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Fown, Stata, Zip Code) 1424 Alberto Dr.

18. Mothar's Nama (First, Middle, Maidan Surnama)

Louise JACKSON 20a. Mathod of Disposition

20b. Placa of Disposition (Nama of camatary, cramatory or other place)

Forestville, mc. 20147

Data 20c. Location - City or Town, Stata

1 Burial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Other (Specify)

21. Signaturifiof Funeral Service Licensee

tarmony Cemeters

10/30/97 LANDOVER INC

Edward

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Suith AND, MY 20746 Approximate Intarvai Between Onsat and Death

Immadiata Causa (Final disaase or condition resulting in daath)

Cerdionegofally

Examiner Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaase or injury that initiated avents rasulting in daath) Last Physician/Medical

Dua to (or as a consequence of)

Due to (or es a consequance of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.

23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown

1 Yas 2 No

2 No

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of cause of death?

Yas 2 No

25. Was casa rafarred to medical examiner? 1 Yas 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

26. Piace of Deeth (Check only ona) Other: 4 Nursing Home 5X Residance 8 □Othar (Specify)

27. Manner of Deeth

5 Panding invastigation 28e. Deta of Injury (Month, Day Year)

28b. Tima of

28c. Injury et Work? 1 ☐ Yas 2 ☐ No 28d. Dascribe how Injury occurred

29a. Cegifier

1 Cartifying Phyalclan: To the bast of my knowledga, daath occurred at the time, date and place, and dua to tha cause(s) and mannar as stated.

2X Madical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated.

295. Signature and title of certifier

29c. Licansa number OCME

OCTOBER 28, 1997

s of parson who complated cause of death (itam 23a) (Typa, Print) HON LOKE MY

31. Data filad (Month, Day, Yaar)

NOV 2 6 1997

111 Penn Street, Baltimore, Maryland 21201 32. Begistrar's Signature

DHMH 16 Rav 6/95

Box 68760, Division of Vital Records, P.O.

The lew requires that the death certificete be executed deteched peeu hes

page 2 certificate

Hospital

the th

0

or Attanding Physician: this After within 24 hours after death. To the Funeral Director: A

Certification: To Watural in by

by

Completed

Be

Medicai

State

Registrar

2 Accidant 3 Suicida

4 Homicida

6 Couid not be datarminad

28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Spacify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29d. Data signad (Month, Day, Year)

97-6784-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene DOROTHY Certificate of Death MOSINHOL 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Month **Physician** Dorothy L. Johnson NOVEMBER 23, 1997 8:22A.M /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A 818 WINSTON AVE BALTIMORE 7. Age (In yrs, lest birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth Augon 2:3 Pey. 1926 NC Sociel Security Number Birthplaca (State or Foreign Country) **Funeral** 1 M 2 F Days Months 220-24-1043 Yrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at MD N/A Baltimore 1 Yes 2 No Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 1122 Darley Avenue 21218 United States Herne 23e Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, Whita, etc. 72 hours efter 1 Never Married 2 Married 1□ Yas 2□ No Baltimore, Maryland 21215-0020 "natural", or 3 Widowed 4 Divorced by FP%Ek Completed traumatic event, the Magical 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hospital Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dietician other 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be h end Mental ! Turner Bunch Hattie Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 Department of Health e Important: If Item 27 Is any Injury or other trac Mrs. Helen Thompson 401 East 25th St., Baltimore, MI 21218 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Nov 28 1 Burial 2 Cremation 3 Removal from State Randallstown, MD King Memorial Park 1997 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22 Name and Address of Facility Calvin L Williams Funeral Service 270 Fredhilton Pass Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or haart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** Immadiete Cause (Final disaasa or condition resulting in death) Cardioviscular disease Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or es a consequence of): ettending physician for use as the burial the death certificate be Physician/Medical Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? the 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b by 24b. Were autopsy findings available prior to completion of causa 24a. Was an autopsy parformad? peen of death? 1 Yes 1 Yes 2 No

page 2 s certificate

Completed Be 25. Was case referred to medical examiner? 27. Menner of Death

Certification: To

Box 68760 0 ۵ Records, Division of Vital To the Hospital of Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certified completely filled in by the funeral director.

Medical

State Registrar

29b. Signature and title of cartifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

investigation

6 Could not be

Hospital:

28a. Date of Injury (Month, Dev Year)

29c. Licensa number O.C.M.E.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only ona)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Data signed (Month, Dey, Year)

NOVEMBER 23, 1997

28f. Location (Street and Number or Rural Route Number, City or Town, State)

David Fowler, M.D.

31. Date filed (Month, Day, Yeer) NOV 2 6 1997

1 XYes 2 No

1 Natural

2 Accident 3 Sulcida

4 Homicide

29a. Certifier (Check only one)

32 Registrary Signature

111 Penn Street, Baltimore, Maryland 21201 Mandalle

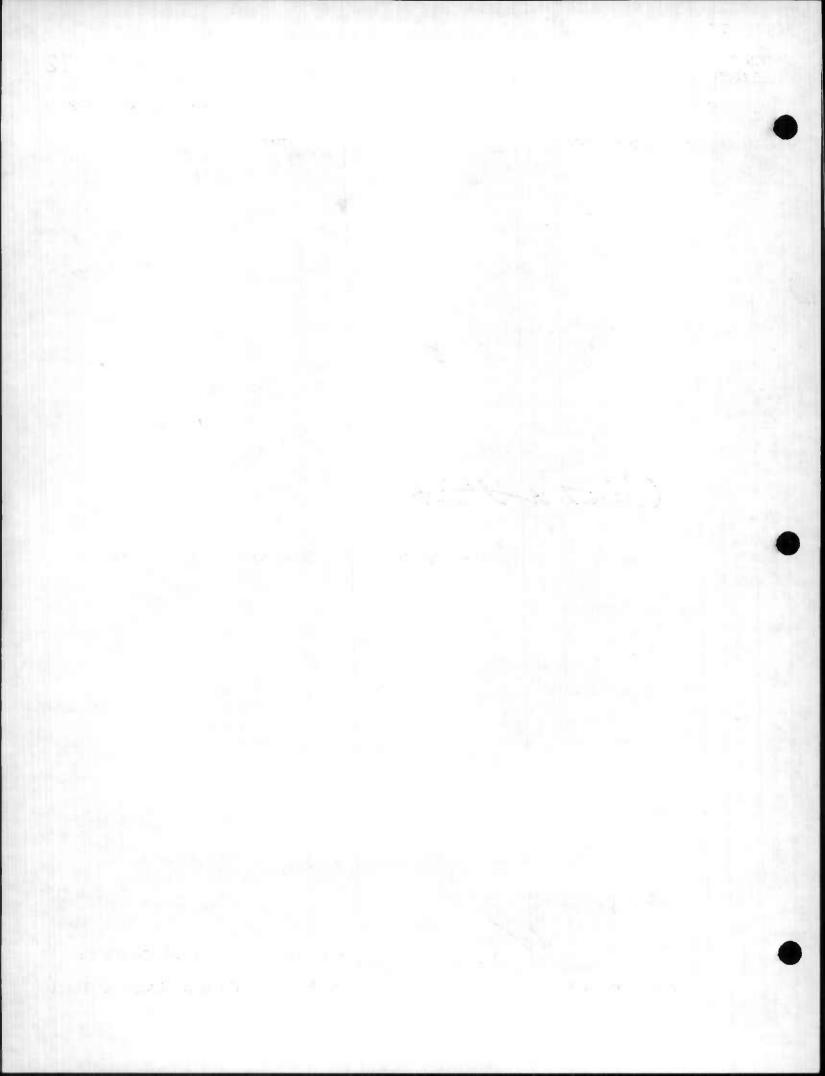
1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28b. Time of

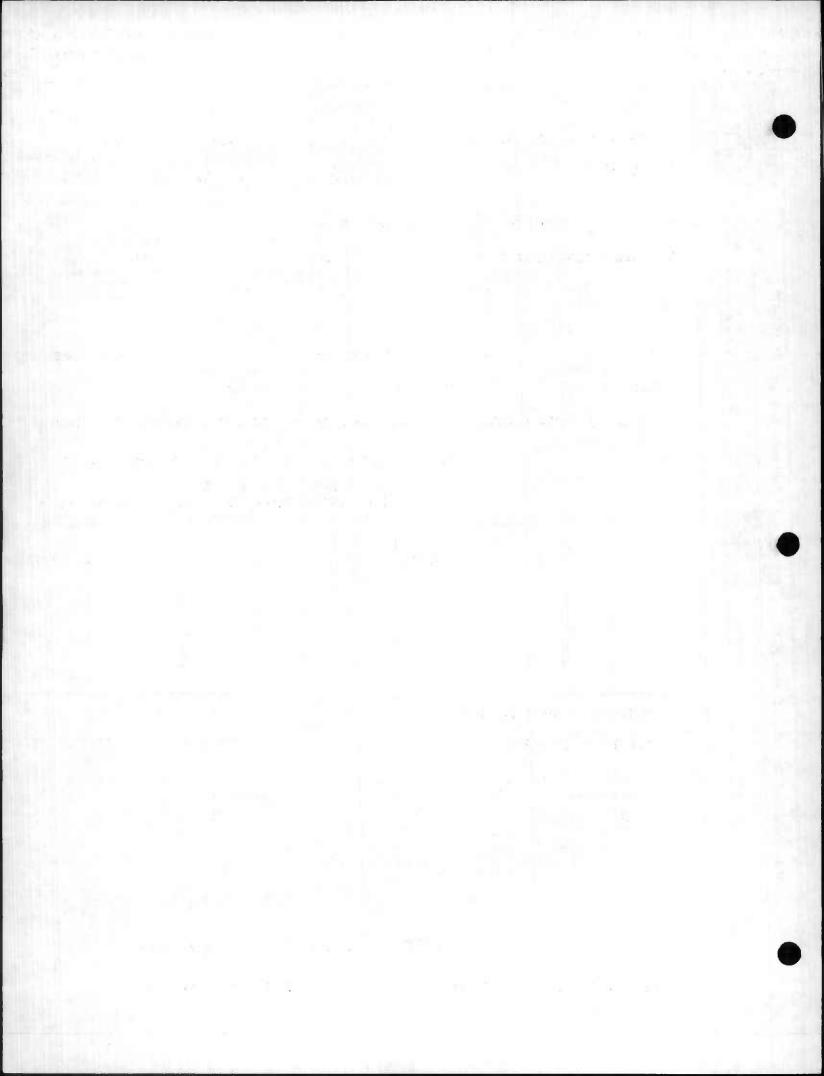
28c. Injury at Work?

1 Yas 2 No



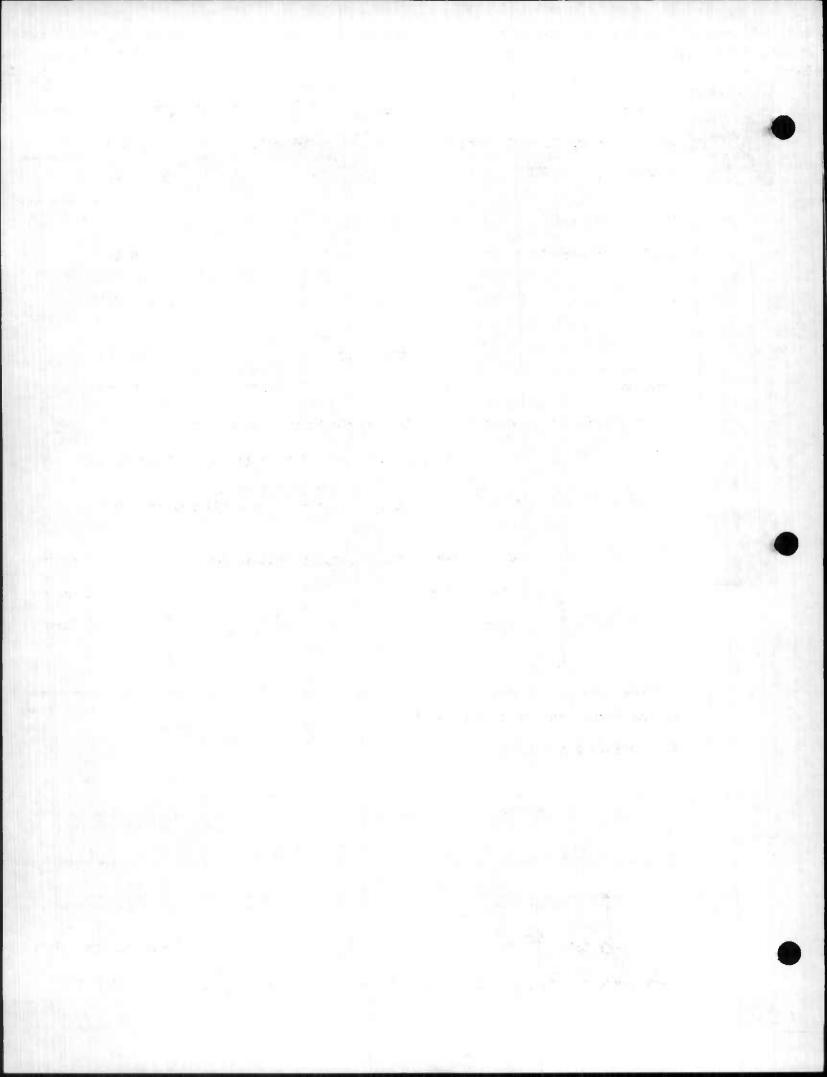
State of Maryland / Department of Health and Mental Hygieneg 7 3587

		4 Day tooth No		t and		Ce	rtifica	te of i	Death	1	Reg. No.	, 0	3013	
Physici	an	Decedent's Na ROSE	me (<i>rirs</i> i, <i>Middi</i>	a, Last)			VIIC	HNER		2. Date of D	Day	Yeer	3. Time of Dee	
/Media	_		/If not inctitution	, give street and num	nhari		NOS			NOV .	20	1997	7 PM	
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Funerai Director		5. Sociel Security 218–32-	-3086	6. Sex 1□ M 2□XF	7. Age (In yrs. 89	last birthday Yrs.	Months Months	Days	If Under 24 H Hours M	in. (Month, D	irth Pey, Year) 9,1907	9. Birth Cot MA	place (State or Fountry) RYLAND	
show d at		Usual Residenca 10a. State	of Decedent 10b. County		10c. Ci	y, Town or Location							10d. Inside City Li	
28a-f shor	ctor	MD	BA	LTIMORE		BA	LTIMO	RE					1 □ Yes 🏋	
or 28	Director	10e. Street and N					10f. Zi	p Code			10g. Citize	n of Whet Co	untry?	
238		24 WARI	REN PARE	DR., APT.	B-1			212			USA			
ral, or itams Examiner of	by Funeral		rried 2 Marr	12. Was Dece Armed For ed 1 ☐ Yes If Yes, Giv Year or Da	rces? X □ No e	J,S. 13.	Was Deca If Yes, spe			(Specify Yes or N erto Rican, etc.)		Black, White		
natural', dical Ex	Completed	(Spe	15. Decedent	's Education t grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind	of Business/I	ndustry	
than the Me	du	Elementery/Sec	condery (0-12)	College (1	-4or 5+)									
2 2 2		12 17. Fether's Neme	e (First, Middle.	Last)			FILE	CLER		eme (First, Middle	-		REVENUE	
ked o	To Be	ISAAC			HAI	RRISON				SARAH		BARBER		
mari umat	-	19a. informent's l	Name/Relations	nip (Type, Print)			ing Addres	s (Street		Rural Route Num			ip Code)	
of Health end Mental F Itam 27 is marked out r other traumatic ever		INA SUS	SAN KUSH	INER (DAUG	.)	24 W	ARREN	PAR	K DR.,	APT. B-1	BALI	O., MD	21208	
ent of Health e nt: If Itam 27 Is ry or other tre		20a. Method of Di	•	3 ☐Removel from Specify)	State	Place of Disponentery, cre HEB SH	metory or	other plea		Dete		ition - City or T		
Department of important: If it any injury or conce.		21. Signature of F								BROS., I	NC.			
		00 - P- 14 F-1		complications that ca					STERSTO			ILLE,	MD 2120 Approximate Interval Between	
	cal Examiner	Sequentieily list of any, leeding to cause. Enter Unc Cause (Disease of the initiated even	conditions, immediate derlying or injury	b	•	or as e conse								
5 6	Med	resulting in death	Last	d	Due to (d	er as a consec	quence of):					i i i		
the att	Physician/	Part II. Other eignificent conditions contributing to death but n				not resulting in the underlying cause given in Pert i. 23b.					b. Did tobacco use contribute to the cause of d			
igned by the attend be deteched for us	by Phy	CONGESTIVE HEART FAILURE					10					1 Yee 2 No 3 Probably 4 Un		
s been s 2 should	Completed l	PRE	VIOUS ST	ROKES							s an eutopsy formed?	a	Vere eutopsy finding veiteble prior to omptetion of ceus f deeth?	
pa	Co									1 🗆	Yes 2	No 1	☐ Yes 2☐ No	
s certificate director, pag	Be	25. Was case refe examiner?	erred to medical	Hospital:				Oth		eath (Check only	one)			
this ald	2		No		npatient 2		-		4 U Nursing	Home 5 Res			ity)	
After fune	Certification:	27. Manner of Death 1 Naturel 2 Accident 28a. Date of Injury (Month, Dey Year) 28					Time of Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe hi					occurred		
	riffe	3 ☐ Suicide 4 ☐ Homicide	6 Could r determi	ned 286. Piece	of Injury - At h ig, etc. (Speci	ome, farm, st fy)	reet, factor	ry, office				Number or Ru	ral Route Number,	
al Director	S	29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(ce, end due to the curred et the time	e ceuse(s) ar , date end p	nd manner as leca, and due	stated. to the cause(s)	
e Funeral Director letely filled in by th	dical Ce	29e. Certifier (Check only one)	2 Medicai I	xaminer: On the ba and menn										
winin 24 nous eiter des To the Funeral Director completely filled in by th	edical	(Check only one)	2 Medical I	and menn	er stated.		29	c. License	number		29d. Date	signed (Month	, Dey, Year)	
within 24 hours enter deep To the Funeral Director: completely filled in by the	Medical	(Check only one)	2 ☐ Medical I	and menn	ERN	IST		D 19				signed (Month		
To the Funeral Director completely filled in by th	Medical	(Check only one) 29b. Signature 30. Name and edd	2 ☐ Medical I	and menn TW who completed cause	ERN				261	S MILLS,	13	-		



State of Maryland / Department of Health and Mental Hygiene 9 7

ysician	_	1. Decedent's Nema (First, Middle, Li	ist)			7 6 6 6		2. Dete of Deeth Month	g. No. Day	Yaer	3. Time of Deeth
/ledical	-	HArry			Kor	ch		Nov 22,	1997	Yaer	7:30 AM
aminer	_	e. Fecility Name (If not institution, gi					4b. City, Town, or L	ocation of Daath	4c. County	of Death	
	Ļ	Howard County Ge		-		W11-1-4 M	Columbia	_		ward	2000
eral Itor			Sex 7.	Age (In yrs. le		If Under 1 Yaar Months Days	if Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Oct 10,		9. Birthple Count Pola	ace (Stete or Foreign ry) and
4	1	10a. State 10b. County		10c. City	, Town or Locat	ion				10	d. Inside City Limits
rector		MD Howard			Col	umbia					XX Yes 2 No
Dir.		10e. Street and Number				10f. Zip Code		10	g. Citizen of V		ry?
- E		5483 Green Dory				2104			-	S.A.	
by Funeral Director		11. Maritel Status 1 Navar Married 2 Married XXXVidowed 4 Divorced	12. Was Deceda Armed Force 1 Tes 2 If Yes, Giva Year or Date	ss?		s Decedent of Fees, specify Cubi	lispantc Origin? (Sp an, Mexican, Puarto Specify:	ecity Yes or No- Rican, etc.)		a - America ck, White, e White	rtc.
Completed		15. Decedent's E (Spacify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4	or 5+)	(Give kin- life. DO		etlon during most of work d)	sing 1	16b. Kind of Business/Industry		
ပိ		17. Father's Name (First, Middla, Las.	1		Propr:	ietor	19 Mother's Nam	e (First, Middle, M		tcher	
o Be C	i	Moishe	,	Koro	ch		Hann		100	Unknov	wn
To		19a. Informent's Name/Reletionship	Type, Print)		19b. Mailing A	Address (Street	end Number or Rur				
To		Mrs Marilyn Bieg	el (Daugi	hter)	11369	Heathe	rtoe Lane	, Columb	ia, MD	2104	4
	2	20a. Method of Disposition 1 XBuriel 2 Cramation 3 [4 Donation 5 Other (Space		1(6		on (Neme of ony or other ple rk, Shaa	rei Zion		oc. Location -		wn, Steta
Suce.		21. Signatura of Funaral Sarvica Lica 21. Signatura of Funaral Sarvica Lica 22. Pert 1. Enter the disaasa, or con shock, or heert failure. List only	111	An .		Sol Le	ringon C	Bros			
er ē		disease or condition resulting in deeth)		Due to (or	es e conseque		lar Coagu	Lation			2 days
Ical Examin		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents	D	Failur	es e consequer	nca of):					3 days 2 days
sician/Medical Examiner		Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avents resulting in death) Lest	Liver	Due to (or Failur Due to (or	es e consequer Ce as e consequer	nca of):	ren in Pert i.	23b. Did tot	ecco use co	ntribute to	
A 100		resulting in deeth) Lest	c. Liver	Due to (or Failur Due to (or	es e consequer as e consequer tting in the unde	nca of):	en in Pert i.		eacco use co s 2∑No	ntribute to	2 days
100		Pert II. Other significent conditions	c. Liver	Due to (or Failur Due to (or	es e consequer as e consequer tting in the unde	nca of):	ren in Pert I.		■ 2 No	3 Proba	2 days
A		Pert II. Other significent conditions of Colon/Rectal Car.	c. Liver	Due to (or Failur Due to (or	es e consequer as e consequer tting in the unde	nca of):	ren in Pert i.	1 ☐ Ye	eutopsy ed?	3 Proba	2 days the cause of death abity 4 Unknow re autopsy findings ilable prior to
Be Completed by Physician/M		Pert II. Other significent conditions of Colon/Rectal Car.	dcontributing to death	Due to (or Failur Due to (or	es e consequer as e consequer tting in the unde	nca of): nca of): orlying cause gh	26. Plece of Deal	1 ☐ Ye	eutopsy ed?	3 Proba	the cause of death ably 4 Unknow re autopsy findings illeble prior to noletion of cause leeth?
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led in by the funeral director, page 2 should be deteched for use a Certification: To Be Completed by Physician/M	2	Pert II. Other significent conditions of Colon/Rectal Car. Polymyalgia Rheu 25. Wes case referred to medical examiner? 1 Yes 2000 27. Manner of Deeth 1000 1	d. Liver d. contributing to death cer; Hypo matica Hospital: Manp 28e. Date of I (Month, n e 28e. Placa of building, ysician: To the be	Due to (or Failur Due to (or h but not result atient 2 Enjury Dey Year) Injury - At hore etc. (Specify) est of my knows of exemination	es e consequer CE as e consequer thing in the unde nalism ER/Outpetient 28b. Time of Injury me, ferm, street.	anca of): artying cause given by the property of the course of the cour	26. Plece of Deal ef: 4 Nursing Ho y et k? Yes 2 No me, date and place, plinlon, death occur a number	24a. Wes en perform 1 Ye. 24a. Wes en perform 1 Ye. 24b. Check only one 28d. Describe how 28f. Location (Str. City or Town, end due to the cared at the time, de	eutopsy ed? s 2 No eutopsy ed? s 2 No oo 6 Oth w Injury occur seet end Numb Stete) use(s) end me te end placa, d. Data signe-	3 Prob. 24b. We ave corror of d 1 Car (Specify, red enner es steand due to d (Month, E	the cause of deeth ably 4 Unknow re autopsy findings illeble prior to npletion of causa leeth? Yes 2 No Route Number, ated. the ceuse(s) Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth 24 **Physician** NETTIE LICHTENSTEIN NOV. 8:45 PM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** BRIGHTWOOD NURSING HOME LUTHERVILLE BALTIMORE If Under 1 Year Months Days 5. Social Security Number 7. Aga (In yrs. last birthdey) 9. Birthpleca (State or Foreign **Funeral** 1 M 2 F MARYLAND 89 Yrs 213-74-8932 Director Usual Residence of Decedent the Maryland 10a. Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Modical Examiner must be nothing at Director 1 Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6503 PARK HEIGHTS AVE., APT. LL 21215 USA Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas Ž☐ No If Yes, Giva Year or Detas: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes X ☐ No Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene Important: if item 27 te marked other than "n any injury or other treumatic avant Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be HARRY GOODMAN ZEIDWERG 9 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PAUL LICHTENSTEIN (SON) 4001 OLD COURT RD., UNIT 402 BALTO., MD 21208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 K Gurlel 2 ☐ Cremetion 3 ☐ Removel from State BETH JACOB ANSHE VESHEAR 11/26/97 4 □ Donation 5 □ Other (Specify) ROSEDALE, MD 21. Signeture of Funeral Service Licenses 22. Nama and Address of Fecility SOL LEVINSON & BROS., INC. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory errest,

Approximate shock, or heart feiture. List only one cause on each line. Intervel Between Onsat end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) atheroscierotic cardiovascular disease 20 years **Examiner** Due to (or es e consequence of): Congestive Weart failure
Due to (or es e consequence of): 20 years Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest 68760, diabetes mellitus Zoyeavs Physician/Medical Due to (or es e consequence of) Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Hypertension Records. by 24b. Were eutopsy findings eveitable prior to completion of causa of deeth? 24e. Wes an eutopsy performed? Completed peed has certificate 1 ☐ Yes 2 No Division of Vital 25. Wes case referred to medical examiner?

1 Yes 2 No Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? i or Attending F after death. Director: After After 1 Naturel 5 Pending 2 ☐ Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D45437 November 25, 1997 OWING MILES, Mary land

State Registrar

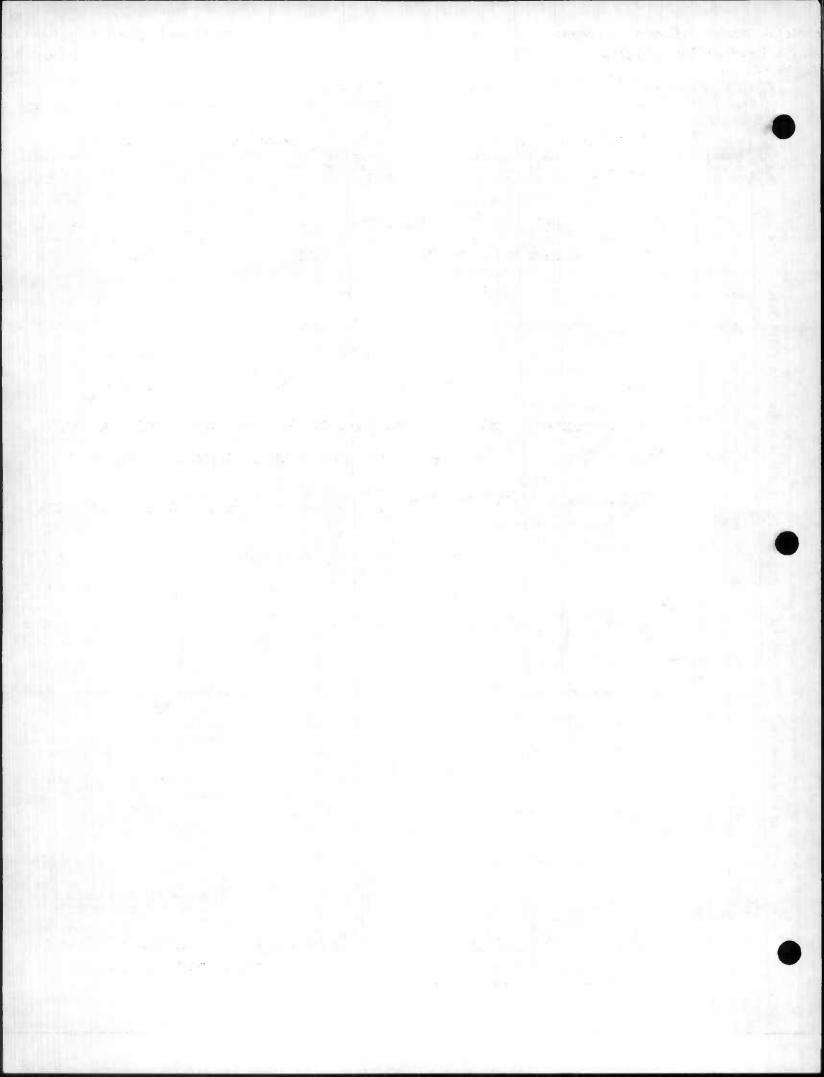
31. Dete filed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) cross roads Drive Suffe 400

NOV 26 1997

32. Registrar's Signature

wha Davidson-Randale



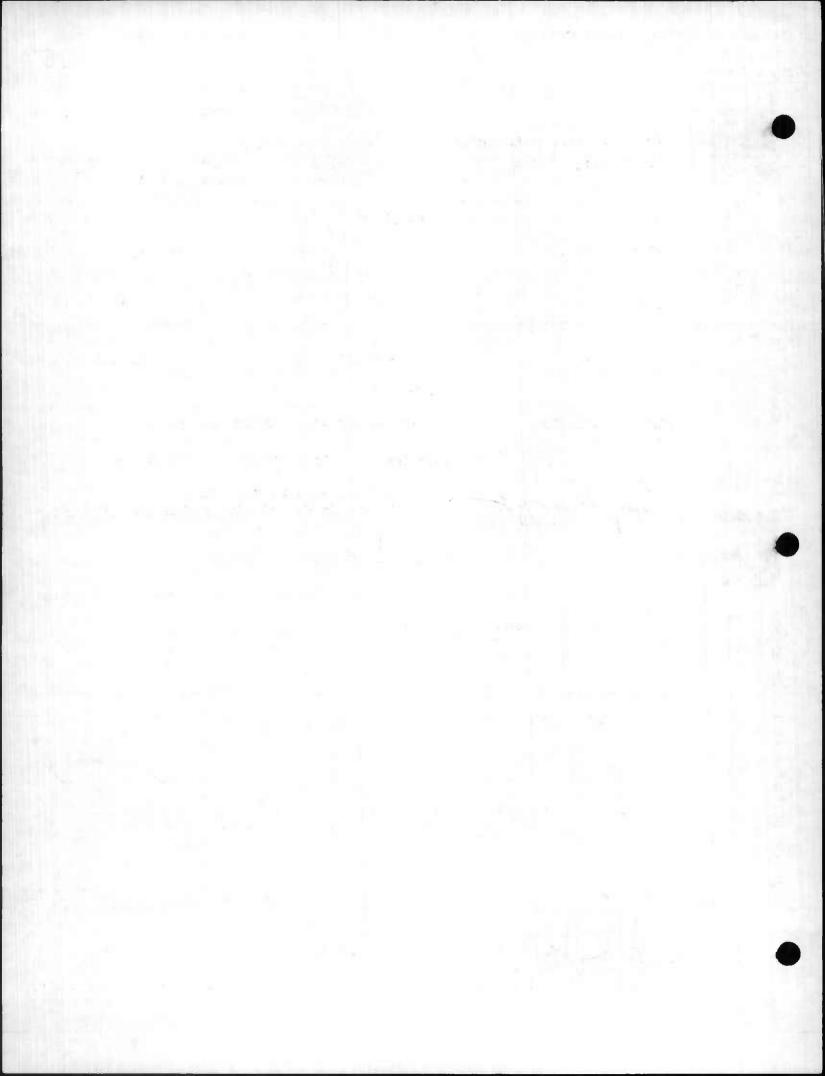
State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ETHEL LEVIN NOV. 1997 /Medical 11:55AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 207-A OAK AVE. (OUR HOUSE) N/A BALTIMORE
If Undar 1 Yaar If Undar 24 Hrs. 8. Dat
Months Days Hours Min. (Mo 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** 1□M 2K F Days Yrs Director SEPT. 9, 1915MARYLAND 82 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at Director MD Y☐ Yes 2☐ No BALTIMORE N/A 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code 6 207-A OAK AVE. 21208 USA "natural", or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: Baltimore, Maryland 21215-0020 1 Yes 3 No Specify: Specify: WHITE p 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health end Mental Hygiene. Int: If item 27 is marked other than "i Elementary/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER OWN_HOME 17. Father'a Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) MORRIS BRONNER ANNA 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health or Important: if item 27 is any injury or other trau MARTIN LEVIN (SON) 59 AMHERST RD. NEWTON, MA 02168 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) AITZ CHAIM 11/23/97 BALTIMORE, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 RETSTERSTOWN RD PIKESVILLE, MD 21208 and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, admin on each line. lle disaasa, or complica t feilure. List only one Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Metastic concever unknown primary
Due to (or es e consequence of): disease or condition resulting In death) Examiner Physician/Medical Examiner End stage chronic dostructure lung disase physician and the burial-transit Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Box 68760, Hypoxemia Due to (or as a consequenca of): for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part i. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 □ Probably 4 □ Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen : Demento 1 Yes 2 No 1 Yes 2 No certificate Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Othar: 4 ☐ Nursing Home 5 ☑ Residence 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) this funeral 27. Menger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 1 Natural 5 Panding 1 Yes 2 No death. invastigation after death Director: A 2 Accidant 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as steted. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D40371 wind completed cause ...

W. Ka play 20 v. ...

32. Registrate Signature

Fundant Davidson Randale Dr Harry (31. Date filed (Month, Dey, Yeer) 20 Crossroads Drive Olings Mills MD 21117 State NOV Registrar

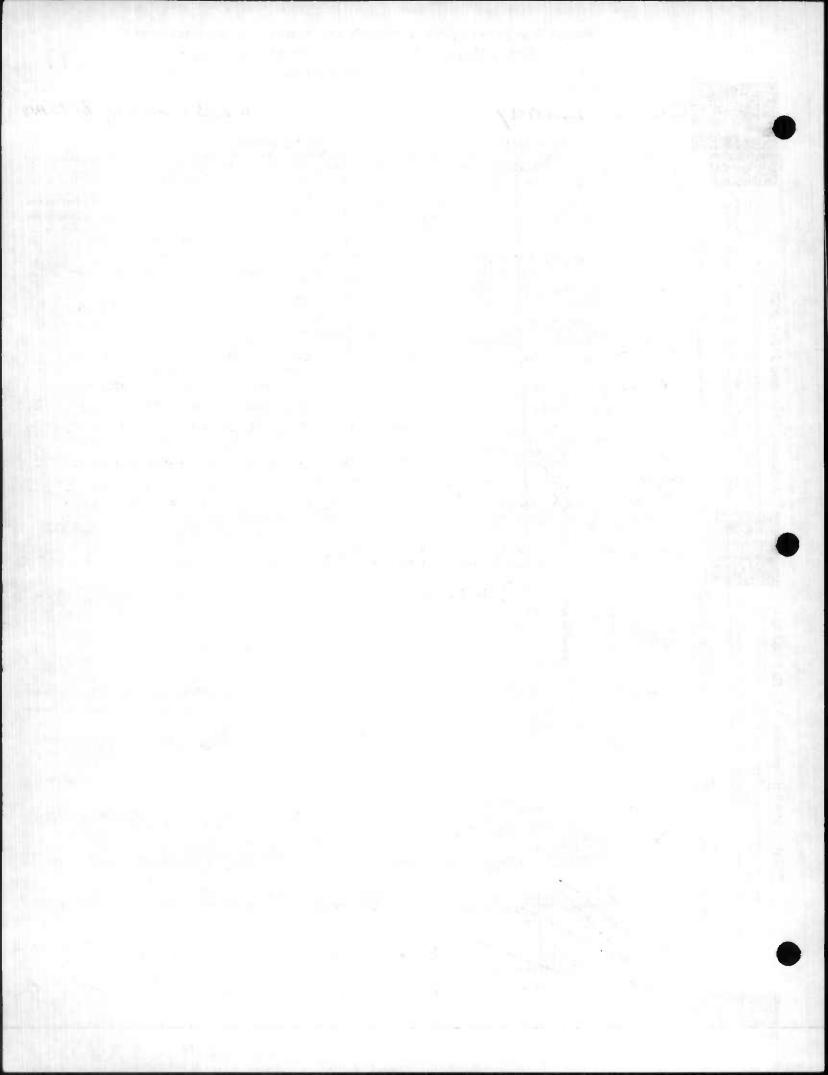


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 22 8:45 AM leta November undy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner John Hopkins Bayview Hospital Baltimore NA If Under 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours 1 M 2 TAF 35 214-84-4603 Director 10-08-62 Md. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at X Yes 2□No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? USA 1212 Bonaparte Avenue 21218 Funeral death 12. Was Dacedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, pemilt. Pages 1 and 2 should be filed within 72 hours effer a Department of Heelth and Mentel Hygiene. Important: If Item 27 is merked other than "netural", or iter any Injury or other traumatic event, the Medical Evantree once. Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify. P 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Spacify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Grade Administrative Clerk Pride Master 18. Mother's Name (First, Middle, Maidan Sumame) 17. Fathar's Name (First, Middle, Last) Andrew J. Lundy Cleta Johnson 0 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleta Α. Lundy 1212 Bonaparte Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Mem. Pk. Cem. 11-28-97 Randallstown, Md. 21 Signature of Funeral Service Llon 22. Nama and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence Examiner physician and s the buriel-trans Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events rasulting In death) Last Due to (or es e consequence of): the death certificate be execu Physician/Medical Dua to (or as a consequence of) 98 980 for ed by the deteched Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. been signed by the should be detech 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy certificate has 1 ☐ Yes 2 No director, 25. Was cese referred to medicel examiner?
1 ☐ Yes 2 No Be 28. Plece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death Certification: 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? Natural 5 Pending investigation or Attending effer death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homiclde 24 hours e Funeral D Carth ind Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 House Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of perion who completed cause of death (Item 23a) (Type, Print) -ucas regor 31. Data filed (Month Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

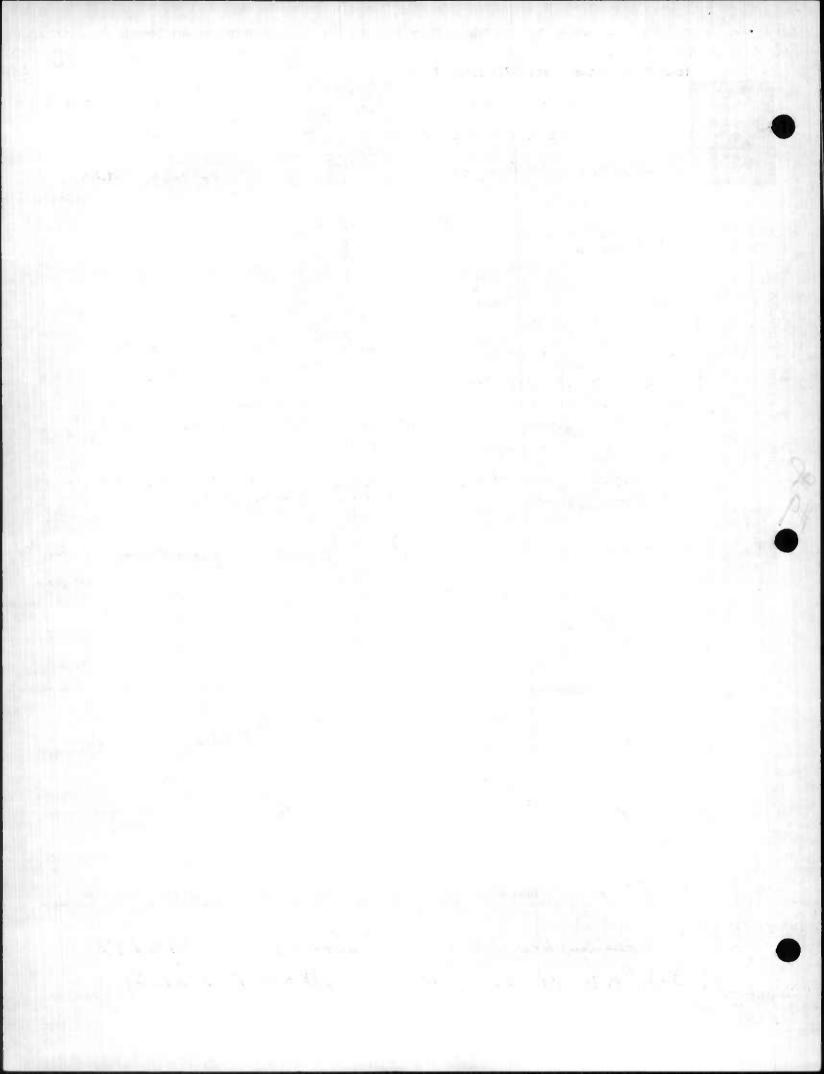


State of Maryland / Department of Health and Mental Hygiene

Item: 9 per Anatomy Board G-753 11/26/97 rebCertificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month 11 **Physician** Day 08 Yee 7 11:29 am Louise L. Letts /Medical 4e. Fecility Neme (If not institution, give street end number) 4h City Town or Location of Death 4c. County of Death Examiner Laurelwood Care Center E1kton Ceci1 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dev, Year) **Funeral** 1□M 20 F Deys Hours 213-01-8042 Yrs. Director 12-25-04 MARYLAND Usual Residence of Decedent the Meryland 10a State 10b. Count 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Cecil Elkton 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? with 100 Laurel Drive 21529 U.S.A. Funeral death 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after. Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or then any Injury or other traumatic event. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White p 3 ➡ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home unknown Homemaker unknown 17. Felher's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Robert Chadwick Larzelere Annie Mary Scarborough 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) P.O. Box 165, North East, Maryland 21901 Nicholas Letts/son 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stele 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stele Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility State Anatomy Board, 655 W. Baltimore Street Konald S. Wade, Director 1.4/97 Baltimore, Maryland 21201 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final cerebrul vascelle Infact (New acl oacl) disease or condition resulting In death) **Examiner** Due to (or es e consequenca of): Examiner Arders varaele diter nel buriei-transit the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last pue Due to (or es e consequença of): physicien s the buriel P.O. Box 68760. Physician/Medicai Due to (or as a consequenca of) for signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 10 3 Probably 4 Unknown Records. by ate hes been signal page 2 should b 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1□ Yes X No certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, I 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. Menger of Deeth 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury el Work? 28d. Describe how injury occurred Certification: 1 Avatural 5 Pending 1 ☐ Yes 2 ☐ No Investigetion **2** ☐ Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner steted. 29a. Certifier Medical 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) gun club Have MD D04823 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) HSU 223 W. Main St ElKton MD 21921 -hih JUI 31. Dete filed (Month, Day, Year) Rissale is Signature State NOV 2 6 1997 Registrar

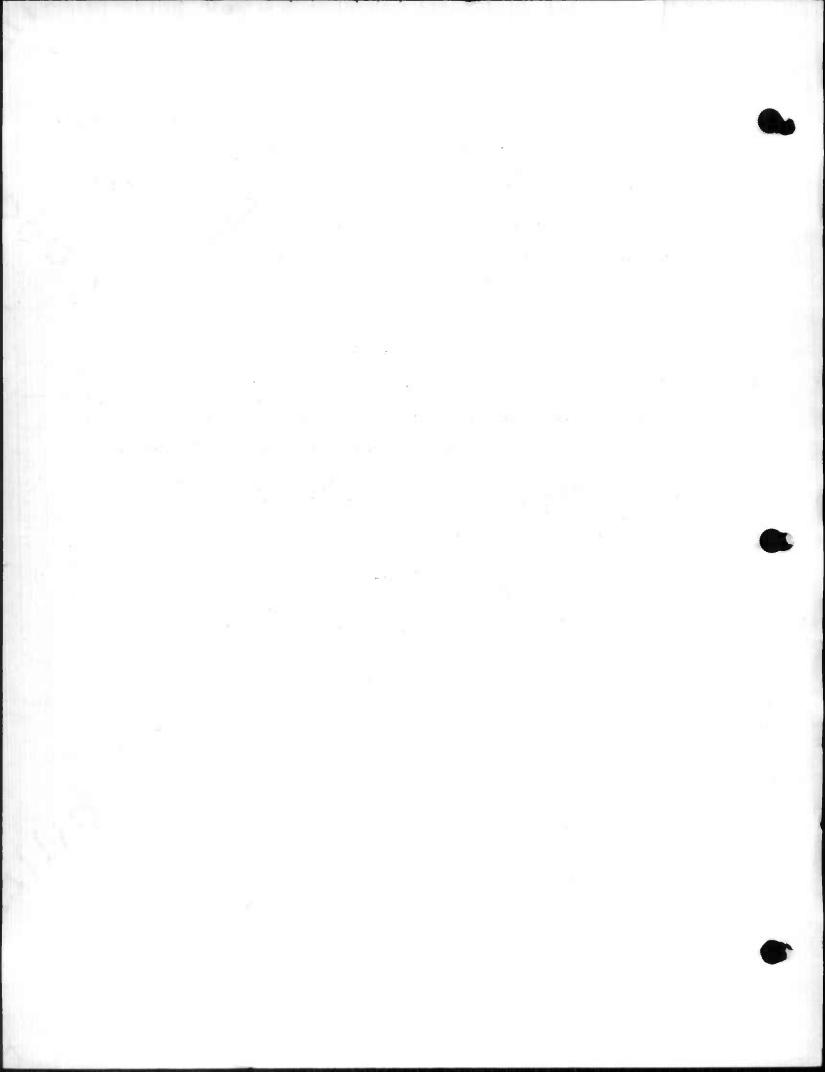
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FRANCISCO
31. DATE FILED (Month, Day, Year)
NOV 26 13

6 1997

	1 - FOR STATE REGISTRAR	STATE OF MAR					EALTH AND DEATH	MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest) JACK				LEV	IN			OV.	1 8 19	97	3. TIME OF DEATH 10:10PM M
	4. SOCIAL SECURITY NUMBER 212-09-1403	1 🛣 M 2 🗆 F 8	AGE (In yrs. les	t birthday) YRS.	IF UNDER	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT	E OF BIRTH	1914	Country MAI	PLACE (State or Foreign RYLAND
TOR	9a. FACILITY NAME (If not institution, give s WESTERN MARYLAN RESIDENCE OF DECEDENT						R LOCATION OF RSTOWN	DEATH		9c. COUNT WAS		GTON
DIRECTOR	10s. STATE 10b. COUNTY	KLEY				ISBUR		17				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 2204 SPRINGFIELD	DR.				101.	ZIP CODE 2540)1		1	N OF W	HAT COUNTRY?
ВҰ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 I IF YES, GIVE WAR (YES 2X N	MED			endent of HISP city Cuban, Mexi 2 NO Spec	Ican, Puerl		or No-	Black Specifi	- American Indian, , White, etc.
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(G	Do NOT us	vork done (during mos	N t of working	10	FOOD		STRY	
ш	17. FATHER'S NAME (First, Middle, Last) MORRIS		L	EVIN			18. MOTHER'S AN		, Middle, Malden		LEV.	EN .
TO B	19s. INFORMANT'S NAME (Types/Print) CECILE B. LEVIN	(WIFE)	191	2204	SPR.	S (Street ar INGF	IELD DR	Poute Nu	mber, City or Tow ARTINSE	n, State, Zip C BURG, V	ode) VV 2	25401
	20s METHOD OF DISPOSITION 1 ABurlet 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		20b. PLACE A	N'O'ABI	FDISPOS KAHAI	M CO	NG. 1			CATION — CH ROSEDA		
	21. SIGNATURE OF FUNERAL SUPPLIES	ALL			S	OL L	EVINSON	& BI			/TT T	E, MD 21208
	23. PART I. Enter the diseasea, or shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	omplications that ce List only one cause of	on each line	ath. Do n	ot enter	the mod	le of dying, su	uch ma ce	rdlec or reap	iratory arres	it,	Approximate interval Between Onset and Death
TION	Sequentially list conditions, if any, leading to immediate	· prac	AS A CONSEC AS A CONSEC	2 de	Reli	ly	s bed	pid.	den	/		28 dap
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO JOH	as a consequence	Mence on Cong	dica estu	id 1	Leave	Fau	lup			
SAL	PART II. Other significant condition	s contributing to dea	th but not n	ngagiting i	n the un	derlying	cause given i	in Part I.	24s. WAS AN PERFOR	IMED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AN: MEDI	DID TOBACCO USE CONTI	RIBUTE TO CAUS					UNCERTA	IN 🗆				1 THE ABOVE
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	Outpatient 3		OTHER 4 I Num	R: sing Home	5 - Residence					1
ВҰ	1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJU (Month, Day, 16	ear)		URY M		ES 2 NO		ESCRIBE HOW I			
ETED	3 Suicide 8 Could not be determined	building, atc.	(Specify)					Ch	OCATION (Street in the street			oute Number,
COMPLET	(Check only 1 CERTIFYING PHYSI one) 2 MEDICAL EXAMINE	R: On the basis of exemi										and manner as stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIES	ubble					De 78	38		D ///	18/	(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO	S COMPLETED CAUSE OF	E C	3 (Typo,	Print)	166	ST. F.	+A6X	Ex570.	עש,	ha	refer 2 na

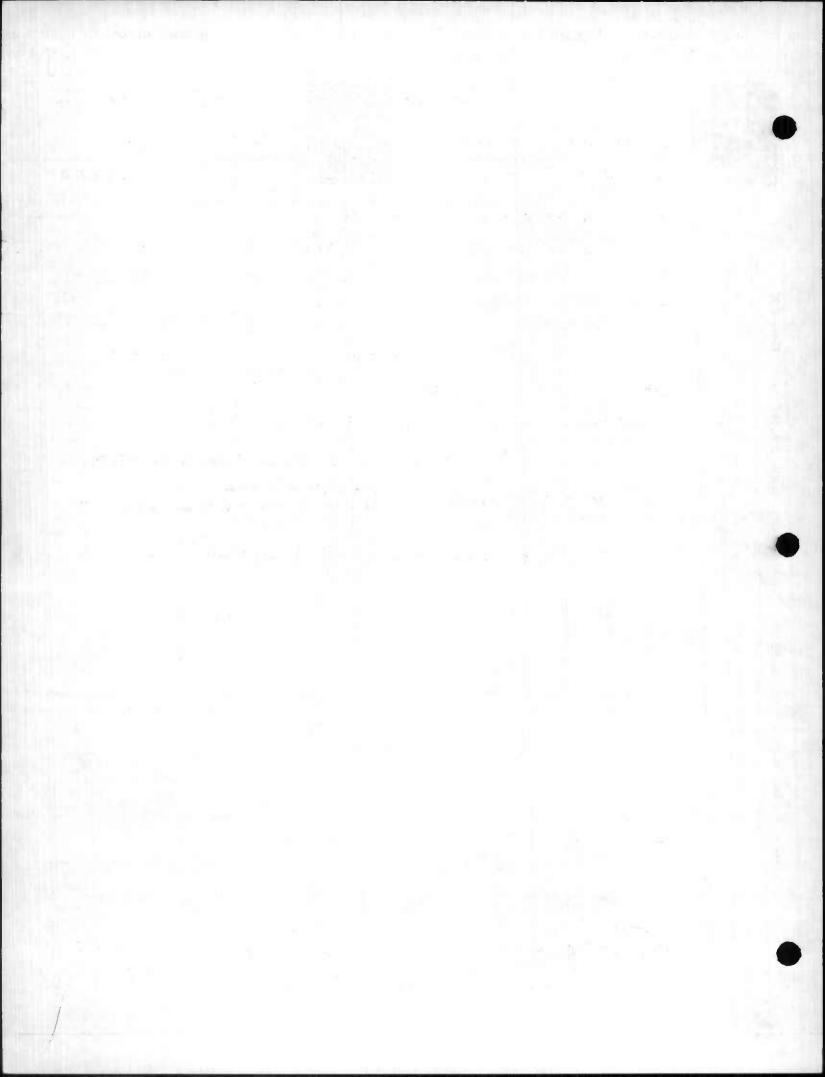


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** MONOVEMBER 24, 199 MOSSOVITZ IDA 9am /Medicai 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17 CLOVELLY CT., APT. 1104 BALTIMORE BALTIMORE If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yea 9. Birthpiece (State or Foreign **Funeral** Months Deys Hours 1 M 2 KF 192-32-9697 87 Yrs Director OCT. 16,1910 MARYLAND Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "nature!", or items 23a or 28a-f show other traumatic event, the Med call Examinat must be notified at BALTIMORE 1 Yes 2 No Director MD BALTIMORE 10f. Zip Code 21208 10e. Street end Number 10g. Citizen of Whet Country? USA with 17 CLOVELLY CT., APT. 1104 deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, permit. Pages 1 and 2 should be filed within 72 hours efter of Department of Healin and Mental Hygiene. Important: If tem 27 is merked other than "naturel", or fee eny injury or other traumetic event, its Medical Eventine. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Xo Specify: WHITE by Specify: 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) TEACHER EDUCATION 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be KOWALSKY HURWITZ ANNIE 2 MAX 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LUTHERVILLE, MD 21093 MELVIN MOSSOVITZ (SON) 18 OLD ELM CT. 20b. Place of Disposition (Name of cemetery, cremetory or other place) Pages 1 a 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetlon 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) ARLINGTON (CHIZUK AMUNO) 11/25/97 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. **Physician** CARCINOMIA-? PRIMARY /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner Sequentially ilst conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Lest Due to (or es e consequence of): physicien and 68760, Physician/Medical Due to (or as e consequence of): attending Box The law requires that the death 0 P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed peen pege 2 has certificate 2 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home Residence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifler Tertifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) and manner as steted.

| Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner steted. Medical (Check only 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 30 Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 1838 GREFHET 32. Registrar's Signeture 31. Date filed (Month, Dey, Year) State who Davidson Randell 2 8 1997 NOV Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item # 20c per FH G753 11/26/97 EW 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death Day 25 **Physician** Marks Month November Tay 00:20am /Medical 4a. Facility Nama (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Sinal Baltimore Hospital Imor If Linder 1 Yeer If Under 24 Hrs. Hours Min. 5. Social Security Number Deta of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1□M 2 F Days 212122773 Yrs Director 76 JULY 23, 1921 POLAND Usuei Residence of Decedent the Maryland 10a Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits ral', or items 23a or 28a-f shore Examiner must be notified at MD BALTIMORE OWINGS MILLS Director 1 AYas 2 No 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? death with 2204 MILLRIDGE RD. 21117 by Funeral USA 12. Wes Decedant Evar in U,S Armed Forcas? Was Dacedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, Biack, White, etc. Pages 1 and 2 should be filed within 72 hours effer onent of Health and Mental Hygiene. 1 Nevar Married 2 Married 1 ☐ Yes 2X No If Yas, Give Yaar or Datas: Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 7 is marked other than "natur traumatic event, the Madical 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) Collaga (1-4or 5+) 12 ADMINISTRATOR MANUFACTURING 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be HARRY ACHTAR BERTHA SHERMAN 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Item 27 is r other tra JAMES MARKS (HUS.) 204 MILLRIDGE RD.

20b. Placa of Disposition (Nama of cematary, cramatory or other place) OWINGS MILLS, MD 21117 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Depertment of Important: If It any Injury or o Finksburg, Md. FINSBURG, MD BETH JACOB 11/26/97 22. Nama and Addrass of Facility
SOL LEVINSON & BROS., INC. 21. Signetura of Funarai Sarvica Licansea 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not enter tha moda of dying, such es cardiec or respiretory errest shock, or haart failure. List only ona causa on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediata Cause (Final Schemic four days disaasa or condition rasulting in death) Examiner Sequentially list conditions, if eny, laading to immediata causa. Entar Undarlying Cause (Disaase or injury that initiated avents rasulting in daath) Last Due to (or es e consaguance of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequenca of) ate has been signed by the atterpage 2 should be detached for Part It. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown ension diabetes hypercholesterolemia Completed by 24a. Was an autopsy performed? 24b. Wara autopsy findings availabla prior to complation of cause of daath? certificate has Hospital or Attending Physician: director, Be 25. Was casa referred to medical 26. Place of Deeth (Check only ona) axaminar? 1 Yes 2 No Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Deet 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After Naturaf Accidant 5 Panding invastigation 1 Yas 2 No within 24 hours after deetl To the Funeral Director: 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicide 29a. Certifiar (Check only one) Certifying Physician: To the best of my knowledga, daath occurred at tha tima, dete end pieca, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On tha basis of examinetion end/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and manner stated. Medical ş 29b. Signature end titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) A52402321 RB9303 November 30. Nama and address of person who completed causa of death (item 23e) (Type, Print)

Sinai Hospital

32. Ragistratis Signatu

of

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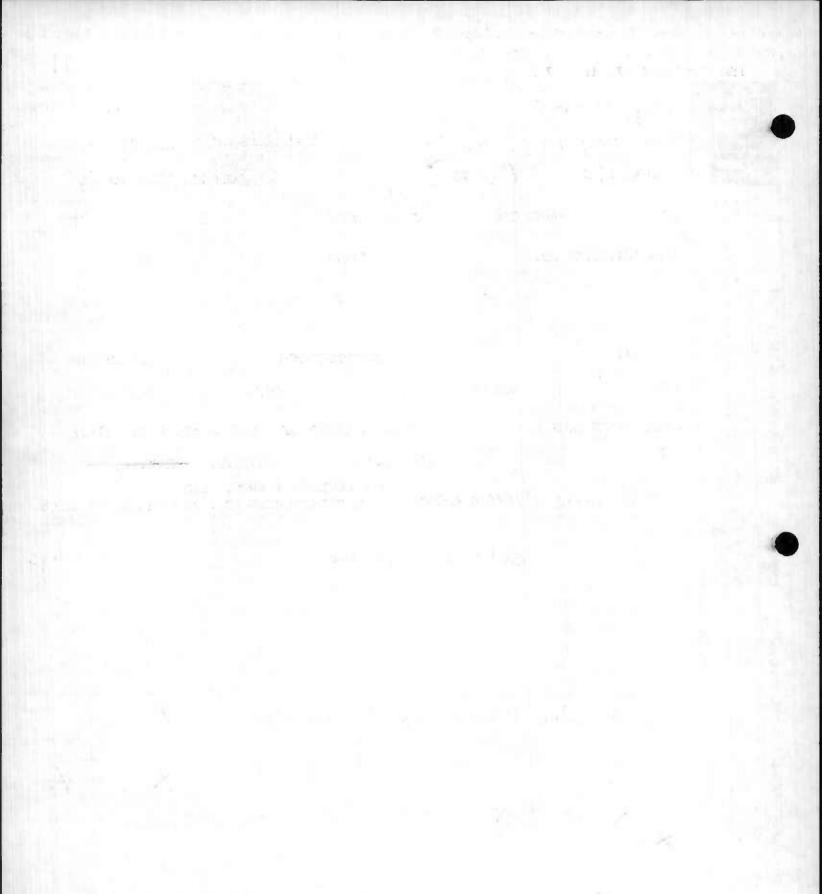
State

Registrar

31. Data filed (Month, Day, Yaar)

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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 25 1997 SAMUEL SMENSH **Physician** Month 01:27 HRS NOVEMBER /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Northwest Hospital Center RANDALLSTOWN BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthpiace (Stete or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, Year) **Funeral** 1⊠M 2□F Months Days Hours 212-01-4140 83 Yrs. Director OCT.11,1914 WASH., DC Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Manyland Department of Heelth and Mantai Hygiene. Important: if term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The House of the contract of the manufacture of the House of 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1 HARNESS CT., APT. T-1 21208 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indien, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SALESPERSON SHOES 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) **JACOB** MENSH UNKNOWN SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CECELIA MENSH (WIFE) 1 HARNESS CT., APT. T-1 BALTO., MD 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CRYPT HAR SINAI CONG. 11/26/97 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & DROS., LIVE.

8900 REISTERSTOWN RD., PIK

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feiture. List only one cause on each line. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Approximete tnterval Between **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or es e consequence of): Examiner DIVERTICULITIS 3 DAYS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and cete be axe Physician/Medical Due to (or as e consequence of) signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown by 24b. Were eutopsy findings svelleble prior to completion of ceuse of death? 24a. Was en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☑ No certificate Division of Vital Hospital or Attanding Physician:
24 hours after death.
 Funeral Director: After this certific. 25. Was case referred to medicel examiner?
1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Dey Yeer) funaral 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Couid not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 I Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier Medical (Check on one) 29d. Date signed (Month, Dey, Year) 29b. Signature title of ogrtifler 29c. License number Hom L MD BG 4439128 NOVEMBER 25, 1997 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) THOMAS GEORGE, NORTHOUST HOPITAL CENTER.

RANDALLSTOWN

32. Pagestian's Sugartine

21133

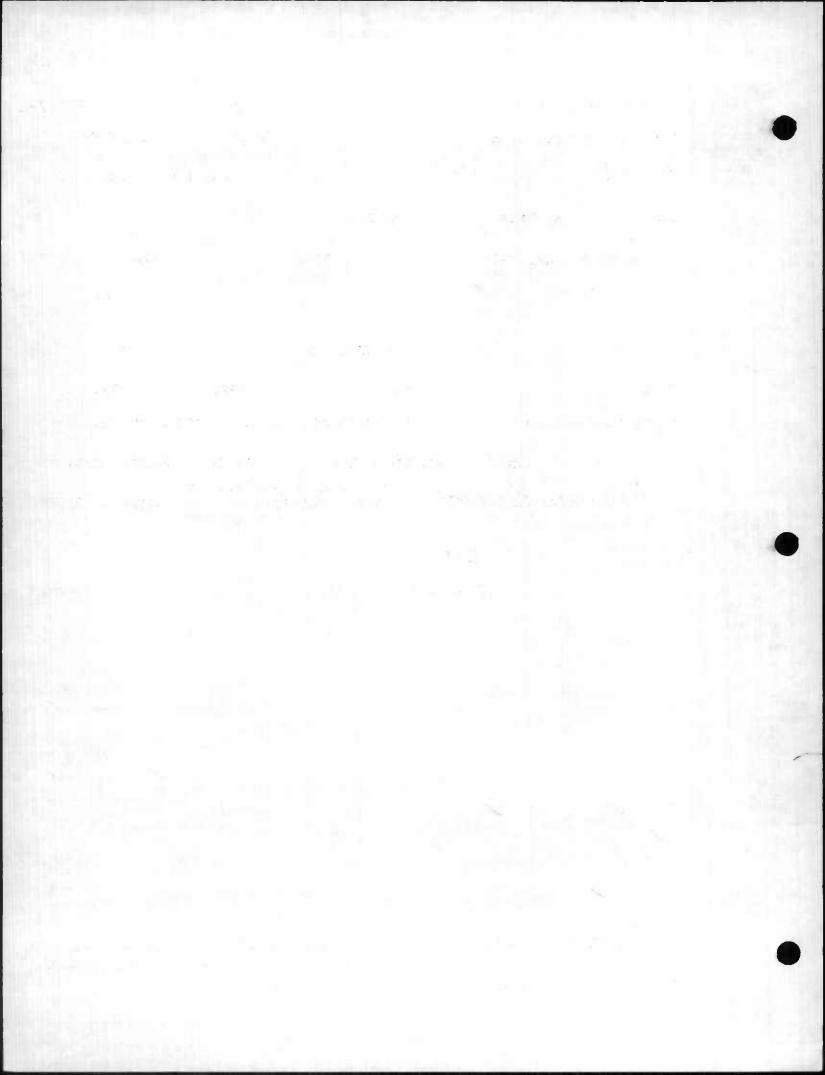
DHMH 16 Ray 6/95

Registrar

5401 020 COURT

31. Date filed (Month; Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 23 ecella 7:17pm 1997 4b. City, Town, or Location of Deeth 4a. Facility Name (If not institution, give street end number) 4c. County of Deeth Hosp Baltimore 7. Age (In yrs. last birthday) At laris 8. Date of Birth (Month, Day, Year) 2-2-1914 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months Days Hours 1 M 2 PF Yrs. Sanford, n.C 220-12-9802 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3203 essman 21216 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Stetus 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Black Specify: 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Maker 12 grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Poke Gable Mlassey Harrington -10-M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Court Hollins Severn Margie lower MID. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State oodlawn Cem. 11-2997 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Owell ave. 108 W. Mouth 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset end Death Immediate Cause (Final Lung Unkouses Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): Part if. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco usa contribute to the cause of death? UBYee 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy 1 Yes 25 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) STEUA MARIS 24 MERLY Other: 4 Nursing Home 5 Residence 6 AOther (Specify) #05PICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

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Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

Item 27 is marked other than "naturel", or items 23s or 28s-f shot other traumstic event, the Medical Examinal must be notified at

Peges 1 end 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. Int: If Item 27 ie merked other than "naturel", or ite

the Maryland

physician and signed by the a

68760, Division of Vital Records. After this certificate has been situated in funeral director, page 2 should in by the funeral of or Attending a after death. To the Hospital o within 24 hours af To the Funeral Di completely filled in

State Registrar

Physician/Medical þ Completed Be 2 Certification:

edical

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29b. Signature end title of certifier

5 Pending investigation

6 Could not be

Zanoren

29c. License number 040480 29d. Date signed (Month, Day, Year) November 24, 1987

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) FERRO, FERNANDO

28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify)

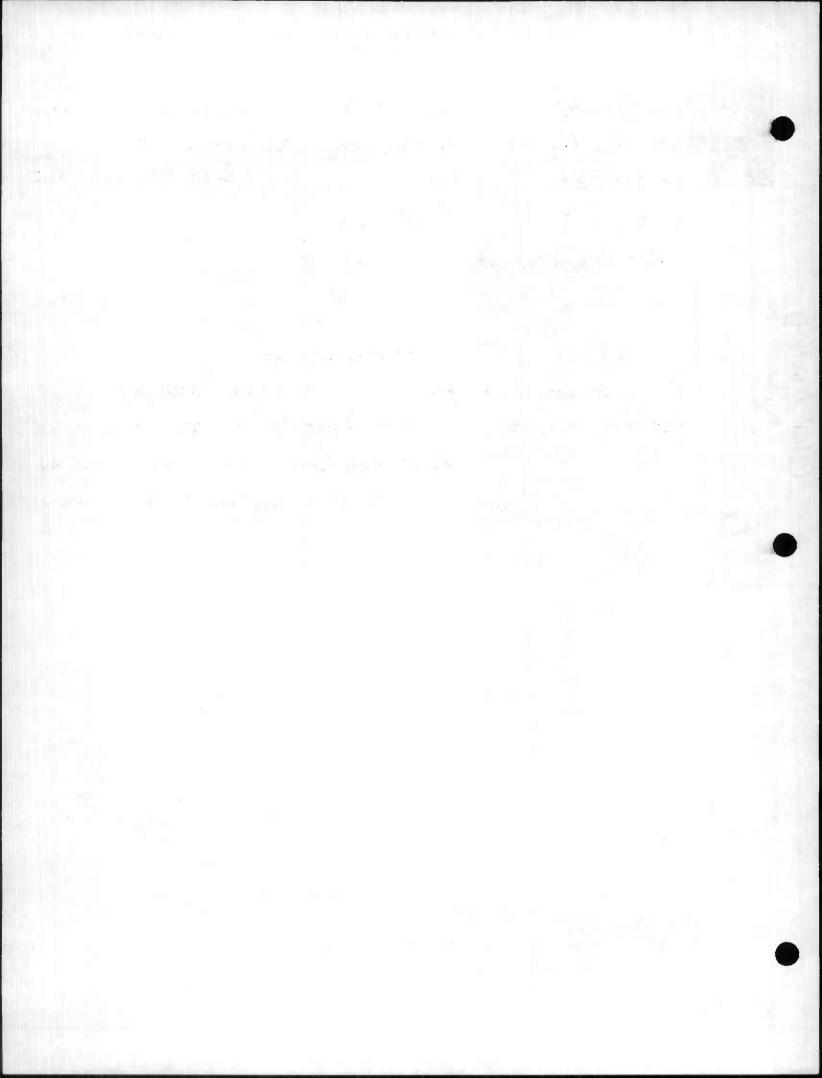
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salair ka

1 ☐ Yes 2 ☐ No

31. Date filed (Month, Dey, Year)

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 24a, per Physician G-753 11/26/97 reb Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Nov. 10, 1997 MARY C.MYERS 9:12 A.M 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Hagerstown Was

If Undar 1 Yaar If Undar 24 Hrs. 8. Dete of Birth
Months Days Hours Min. Dec. 1721 Washington

9. Birthplace (State or Foreign Country)

Country 13107 Orchid Dr. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 1 M 20 F 201-18-0844 Vre Usual Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Md. Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13107 Orchid Dr. 21740 USA 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Married 2 Married Yes 2 No f Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coltega (1-4or 5+) Nursing assistant Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Sumema) William Hornbaker Susan Maria Sword 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 13107 Orchid Dr., Hagerstown, Md. 21740

as of Disposition (Name of Date 20c, Location - City of Town, Stata Mercersburg, Beverly Ann Montgomery 20a. Method of Disposition 20b. Placa of Disposition (Neme of cematery, cremetory or other place) 1 Burial 2 Cremation 3 Ramoval from State Fairview Cem. Franklin Co., Pa. 22. Name and Addrass of Facility Lininger-Fries F. Home 47 N. Park Ave., Mercersburg, Pa. 17236 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death

Physician /Medical Examiner

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physician the

ed by the detached signed by t

Department o Important: If any injury or

Physician

/Medical

Examiner

10a. Stata

Director

Completed by Funeral

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Director

Show

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinating the notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health end Mentel Hygiene.
ant: If Item 27 ie marked other than "natural", or Items 23.
ury or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0020

the Maryland

or Attending Physician: The law requires that the deeth certificate be executed after death.

Director: After this certificate has been signed by the ettending physician and

Division of Vital Records, P.O. Box 68760.

Immediate Cause (Final disease or condition rasulting in death)	a. Cardi	o pulmas	g arren		7 money
Sequantially list conditions, if any, leading to Immediate	b. Metast	or as a consequence of	Breast a	encel	
cause. Enter Underlying Cause (Disease or Injury that initiated avents rasulting in death) Last	C Due to (d	or as a consequenca of)			
Part II. Other significant conditions co	ntributing to death but not res		causa given In Part I.	23b. Did tobacco use co	patribute to the cause of death?
	***	0		24a. Was an autopsy performed?	24b. Wera autopsy findings available prior to completion of cause of death?
25. Was case refarred to medical				1 ☐ Yes 🐰 🖾 No	1 Yes 2 No
avaminar?	Hospitat: 1 ☐ Inpatient 2 ☐	3500	Other	eath (Check only one)	
27. Manner of Death 1 ☑Natural 5 ☐ Panding 2 ☐ Accident Investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work?	Home 5 ☐ Residence 6 ☐ Oti 28d. Describe how Injury occu	
3 Suicida 8 Could not be determined	28a. Place of Injury - At h building, etc. (Speci	ome, farm, straet, factor fy)	y, office	28f. Location (Street and Num. City or Town, Stata)	ber or Rural Route Number,
29a. Certifiar (Check only one) 1 Certifying Phy 2 Medical Exami	elclan: To the best of my kno ner: On tha basis of examina and manner stated.	owiedge, daath occurred ation and/or Invastigation	at the tima, date and place, in my opinion, death occ	e, and due to the cause(s) and m urred at the time, date and place,	anner as stated. and due to the causa(s)
29b. Signature and title of certification	lule	29	D 27898	29d. Data signe	ed (Month, Day, Year)

Hazerton, MO 21780

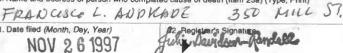
State Registrar

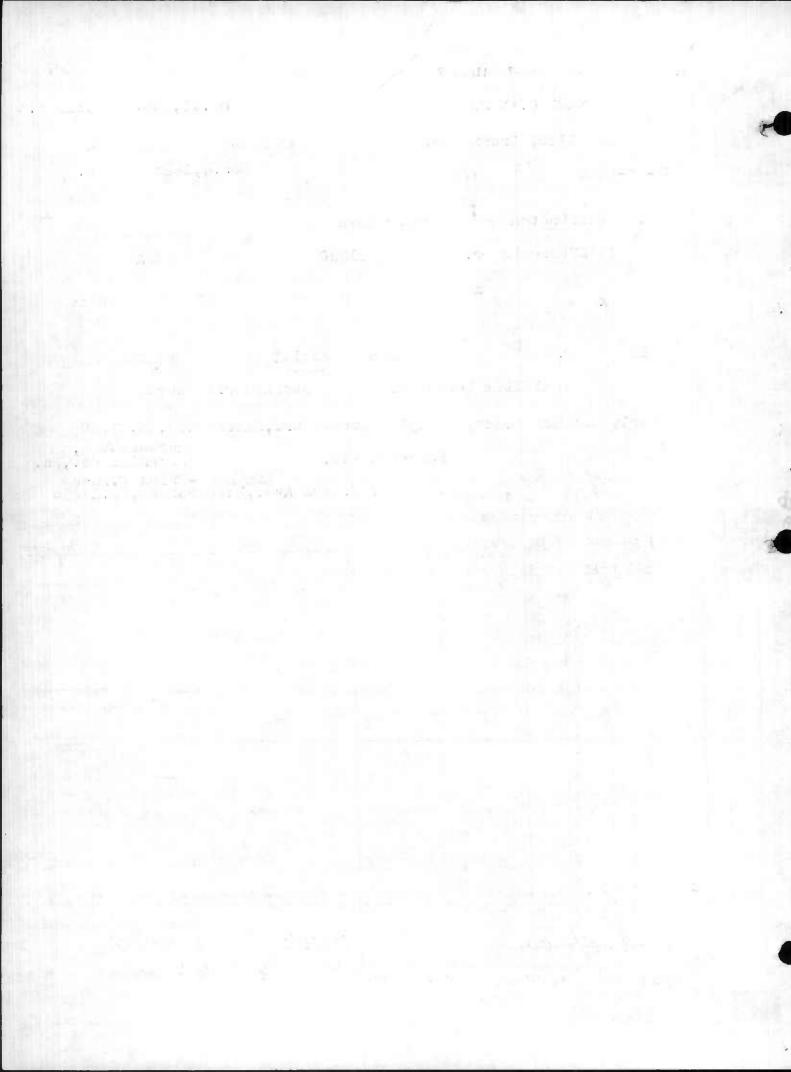
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To the Hospital o within 24 hours af To the Funeral D completely filled i

31. Date filed (Month, Dey, Year) NOV 26 1997

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)





Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Item: 1 per Physician 11/25/97 reb G-753 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Howard Louis Martin A/K/A Martinuzzi 02:15 am November 18 1997 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth BALTIMORE ST. AGNES HEALTHCARE If Under 1 Year Months Days Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) 1 ☑ M 2 ☐ F 220-24-5592 JUN 23, 1930 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Catonsville 1 Yes 2 No 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21228 74 Mellor Avenue USA 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Stetus 1 to Yes 2 No If Yes, Give 1947 – Yeer or Detes: 1948 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4+ Nurse Health 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John F. Martin Margaret G. Nichols 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 74 Mellor Avenue, Catonsville, Md. 21228
ce of Disposition (Name of pete 20c. Location - City or Town, Stete Ramona E. Martin - wife 11/_{21/97} 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1XX)Buriel 2 Cremetion 3 Removel from State Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Pk. 22. Name end Address of Fecility Gary L. Kaufman Funeral Home at Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear feilure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Cardiac ar Rhythmia minutes Due to (or es e consequence of): minuter Pailure Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): hours Respiratory Pailme Due to (or es e consequence of): days Intracertebral hemourhage 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown myocardial infarction 24b. Were autopsy findings evellable prior to completion of cause of deeth? 24e. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Physician/Medicai þ

Completed

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Certification:

Medical

Examiner

Physician

/Medical

Examiner

Director

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Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Madical Examiner must be notified at

il Hygiene. other than "natural", or ite

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permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is m any Injury or other traum once.

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Examiner

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NAME: Mart IN, Howard

Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert t.

27. Menner of Deeth

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one) 1) Certifying Phyeictan: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the cause(s) end menner steted.

29c. License number

29b. Signeture end title of certifier

M.D.

29d. Dete signed (Month, Dey, Year)

21229

P11698

Baltimore

November

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

PariKh Rupesh 31. Dete filed (Month, Day, Yeer)

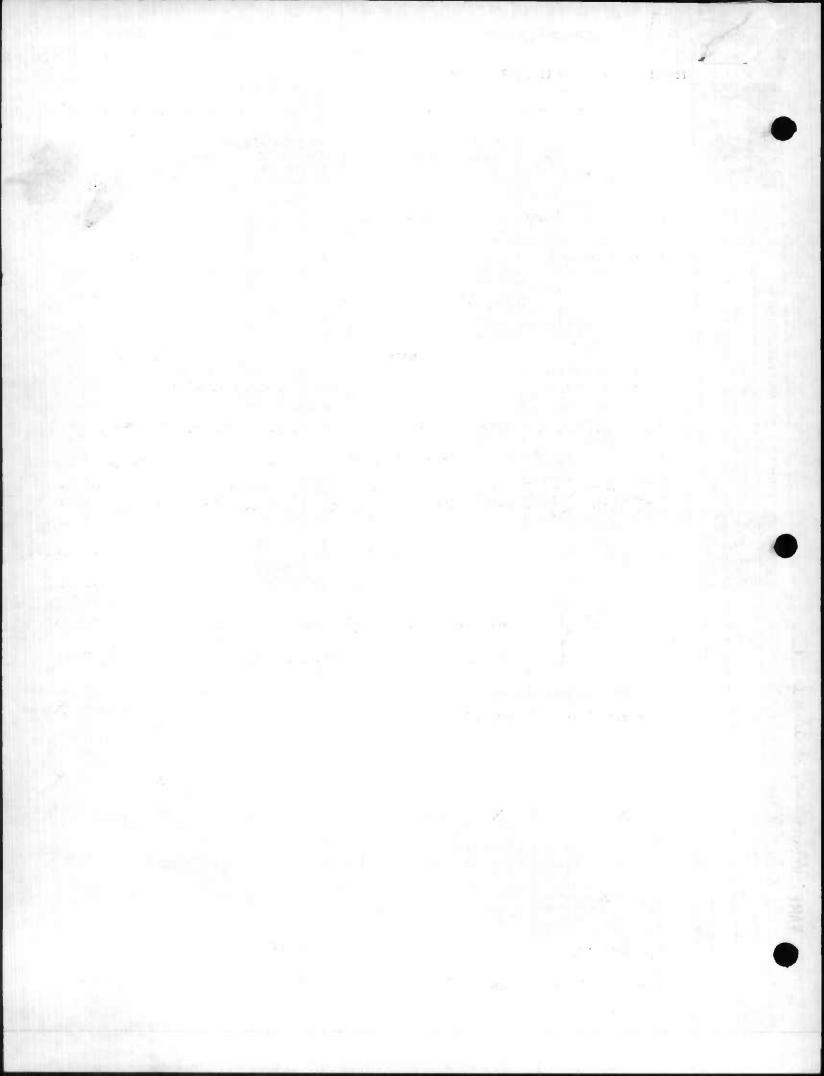
NOV 251997



State Registrar

after death. Director: Aft

To the Hospital within 24 hours of to the Funeral Completely filled



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene /

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** ANNETTE C. MICHEL November 18, 1997 8:30a.m. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner STELLA MARIS HOSPICE TOWSON BALTIMORE 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) JAN 15, 9. Birthplece (Stete or Foreign **Funeral** Deys 1□M 2√F PENNSYLVANIA 203-26-6657 63 Yrs. 1934 Director Usual Residence of Decedent the Maryland 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits show An "natural", or items 23s or 28s-f show Wedical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4305 MARBLE HALL RD. 21218 USA Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. filed within 72 hours effer Hygiene. Ither than "natural", or item 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 No Specify: WHITE by 3 Widowed 4 Divorced Completed 15. Decedent's Education 16e. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) at i HOMEMAKER Peges 1 and 2 should be filed withment of Health end Mental Hygien tant: If item 27 is marked other thighery or other traumatic event, this OWN HOME Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS Η. MICHEL BERTHA WEINER 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JACOB A.MICHEL (BRO) 19290 S.W. TRELANE ALOHA, OR 97006 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removel from Stete permit. Pege Department of Important: If any Injury or once. TOWSON, MD HILLTOP SERV. CORP. 11/20/97 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service License 2300 LEVINSON BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, only one cause on each line. 23a. Pert1. Enter the diseese shock, or heert feilure. Approximete Intervel Between Onset end Deeth Physician /Medica Immediete Cause (Finel diseese or condition resulting in death) **Examiner** Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): be execu Box 68760. physician Physician/Medical The law requires that the death certificate the Due to (or es e consequence of): detached P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t Records, by 24b. Were eutopsy findings evalleble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy page 2 s 1 Yes 1 ☐ Yes 2 ☐ No certificate Vital Physician: director, Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 1 Yes 2 No HOSPICE of this the funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred After Division or Attending 5 Pending Investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide in by t 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 29a. Certifier ts Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) end menner stated. Medical completely (Check only one) the 29b. Signeture en 1 life of partition 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. PENELOPE EDWARDS

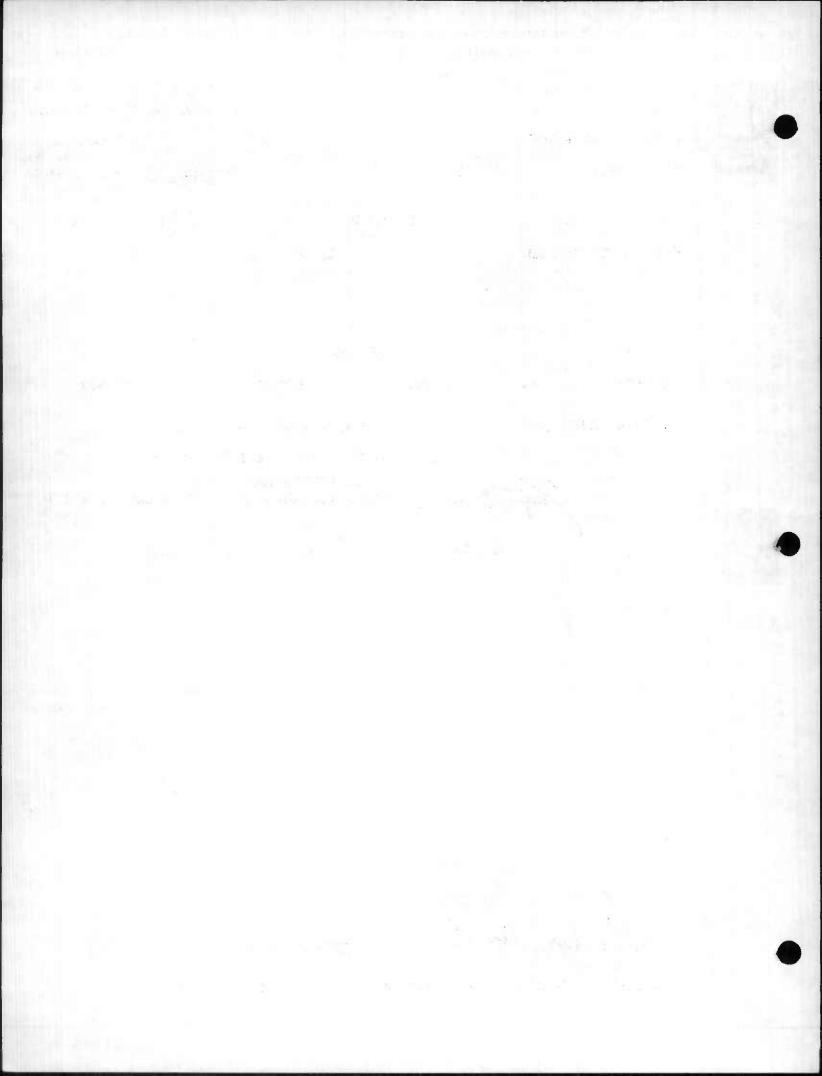
32. Registrate Signature

Guna Pavidson

Registrar **DHMH 16 Ray 6/95**

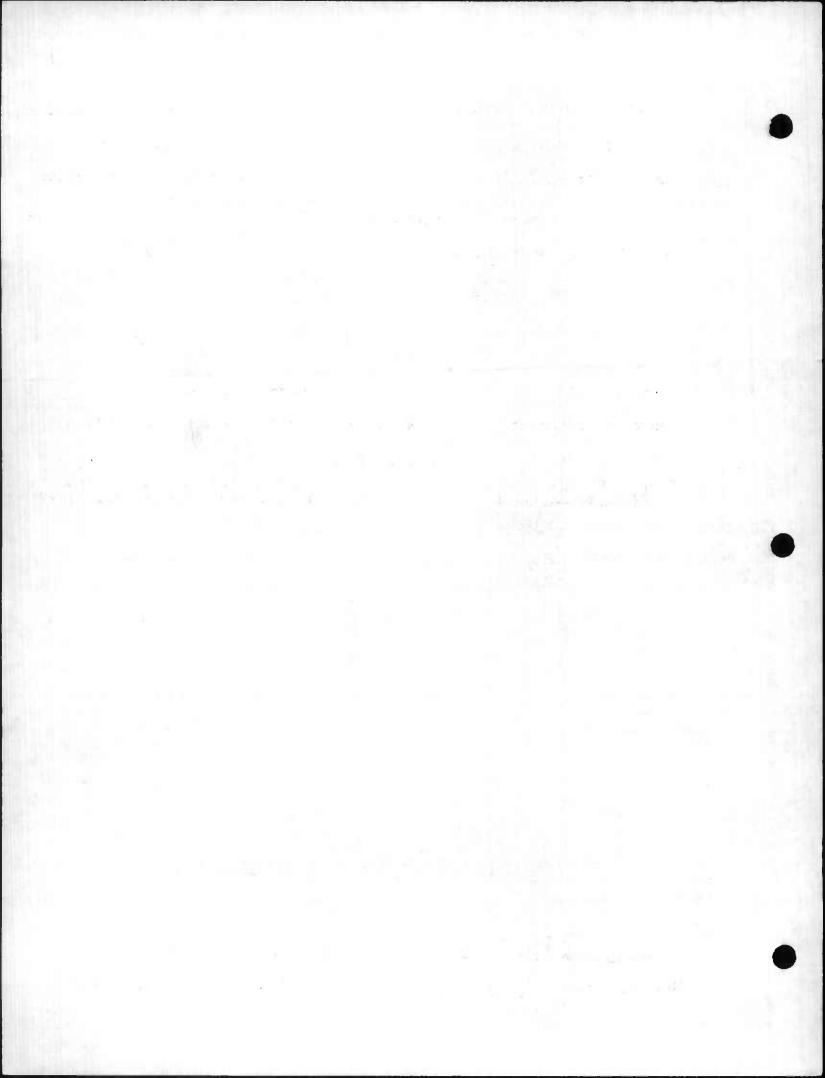
State

31. Dete filed (Month, Day, Year)



	Decedent's Name (First, Middle, La	et)	Cel	tificate of	Death	2. Dete of De	Reg. No.	T	2 Time of Death
cian	NORMAN EDGA					Month	Day	Year 1997	3. Tima of Death 2:55 PM
l i cal iner	4a. Fecility Name (If not Institution, give				4b. City, Town, or	Location of Death			Z:33 PM
	Multi Care Cer	nter			Towson		Balt	imore	9
i	5. Sociel Security Number 6. S	ex 7. Age (in □xM 2□ F 81	yrs. last birthday) Yrs.	If Undar 1 Yaar Months Deys	Hours Min		y, Year)	9. Birthpla	ca (Steta or Foreign y) cyland
	213-01-1005 Usuel Residence of Decedant					pept.2	0,1910	_ Mai	Lyland
	10a. Stata 10b. County		City, Town or Lo					100	d. Inside City Limits
ecto	-4	imore 1	Baltimo				40 000 41		1 □ Yes 2/CM0
ai Dir	10e. Street end Number 8207 Loch Rave	en Bouleva:	rd	10f. Zip Code 2128	6		10g. Citizen of V US		γı
by Funeral Director	11. Marital Status 1 □ Naver Merried 2 □ Married 3 ☑ ₩idowed 4 □ Divorced	12. Was Decedant Ever Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	H	Ves Decedent of it Yes, specify Cub	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, atc.)		ca - America ck, White, et y: Wh	
Completed by	15. Decedent's E (Specify only highest gra	ducation	16a. Deced	ent's Usuei Occup	pation	ndina	16b. Kind of B	usiness/Indu	stry
mpie	Elementery/Secondery (0-12)	Collega (1-4or 5+)		kind of work done OO NOT use retire	d)	nkiig	Owner		
	8 17. Fsther's Nama (First, Middle, Last		Bar	ber	18 Mother's No	ma (First, Middle,	Barbe		op
o Be	Horace Miller					e Rosie		10)	
To	19a. Informant's Name/Relationship (Type, Print)	19b. Mellin	g Address (Street		ural Route Numbe		Steta, Zip C	Coda)
	Howard E. Ro					Parkto			
H	20e. Method of Disposition 1 X Yurial 2 Crametion 3 C 4 Donetion 5 Other (Specif	Removal from Stete	b. Pleca of Disponentery, cremetery, cremetery	netory or other ple	ce)	11/ ^{Pete} 22/	20c. Location · White		
	21-Signature of Funeral Service Liger	P.	-	Nema and Addra		J.J.Har			
	Steven blood	edus?	2	4 Secor		New Fr			
Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due b.	to (or es a conseque to (or es a conseque	uence of):			· •		Vect v S
Physician/Medical Ex	if sny, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in deeth) Last	c	o (or as a consequ	uenca of):					
sicia	Pert ii. Other significant conditions o	ontributing to death but not	resulting in the ur	derlying cause gi	en in Part f.	23b. Did 1	obacco use co	ntribute to t	the cause of death?
by Phy	Presmonia					8	Yes 2□No	3 Probe	ably 4 Unknown
Completed t							en eutopsy med?	avaii	e autopsy findings leble prior to pletion of cause seth?
Con						101	res 20 No	10	Yes 2□ No
Be	25. Was case referred to medical examinar?	Hospitei:		_ 00		eth (Check only o			
ation: To	1 Yas 228 No 27. Menner of Deeth Neturel 5 Pending 2 Accident Invastigation	1 ∐ Inpatient 28e. Deta of injury (Month, Day Yea	2 ER/Outpatien 28b. Time of fnjury	28c. Inju Wo	Nursing	Home 5 ☐ Resid	dence 6 Oth		
Certification:	3 Suicida 6 Could not b 4 Homicide determined	28e. Pieca of injury - A building, atc. (Sp.	At home, farm, streecify)	eet, factory, office		28f. Location (S City or Tox	Street end Numb vn, Steta)	ber or Rural i	Route Number,
edicai (29e. Cartifiar Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of examend mannar steled.	knowledge, death nination and/or inv	occurred at the tile estigetion, in my o	ne, dete end plec ppinion, daeth occ	e, and due to the urred at the time,	cause(s) end mo dete end pieca,	enner es sta snd due to t	ted. the cause(s)
Me.	29b. Signature end title of certiller	00		29c. Licans	se number		29d. Data signe	1.	ay, Year)
	Da said	Trelend	an	03	8127		11/30	197	
	30. Nama and address of person who Howard S. Freela		(Item 23e) (Type, I	Print) Raveu	Blud, 8	Saltimo	re mo	919	39
_	31. Dete filed (Month, Day, Year)	32. Registrer's S							

DHMH 16 Rev 6/95

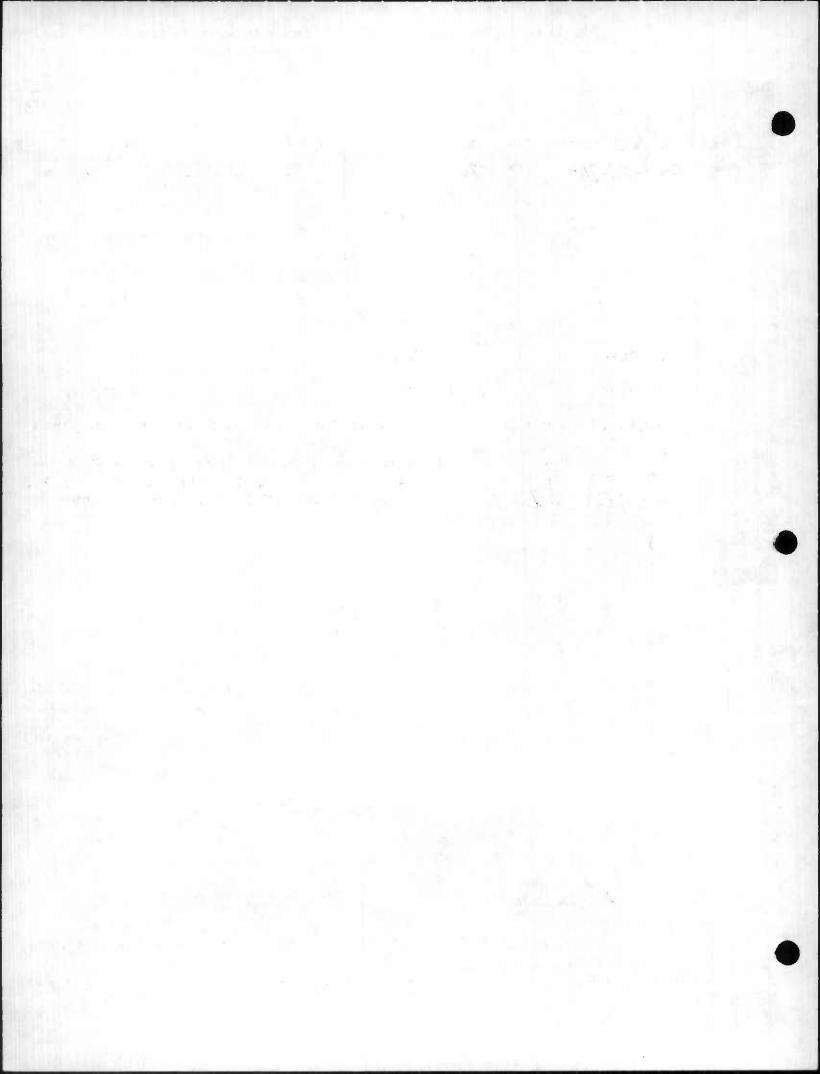


State of Maryland / Department of Health and Mental Hygiene 35888 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** ESSIE NOVEMBER 21, 199 NESBITT 0620 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b, City, Town, or Location of Deeth **Examiner** Baltimore Church Nursing Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country)
 SC **Funeral** 1 M 2 K Deys Director Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. tnside City Limits TRAIN De notified at Md. Director NA Baltimore XXYes 2 No 10e. Street end Number 10f. Zto Code 10g. Citizen of Whet Country? items 23e 102 West North Avenue 21201 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Meritei Status 14. Race - American indien, Bieck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: if Itam 27 is marked other than "natural", or its important: of the way injury or other traumatic event, the Wed all Examinations. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade comp 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rede completed) Elementery/Secondery (0-12) Coitege (1-4or 5+) 7th Grade Disabled Laborer 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Lovelace Thomas Addlu Thomas 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21201 Reginald Thomas 102 West North Avenue Baltimore, Maryland 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burlei 2 ☐ Cremetion 3 ☐ Removei from State 4 □ Dgnetion 5 □ Other (Specify Voshell Mem. Gardens 11-29-97 Dundalk, Md. 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Physician /Medical immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in deeth) Examiner Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Due to (or es e consequence of) P.O. Pert fi. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by 1 Tes 2 No 3 Probably 4 Unknown HYPERTENSION Records, by Be Completed 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? CONGESTIVE HEART FAILURE 1 Yes 2 10 certificata Division of Vital or Attending Physician: 25. Wes case referred to medical 28. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA filled in by the funeral 27. Manner of Deeth 1 Naturel 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? After 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 Yes 2 □ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyercfan: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner steted. Medical 29e. Certifier completely (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40356 med - Specialist 30. Name end eddress of pereon who completed ceuse of death (Item 23e) (Type, Print) 100 N. Broadway, Baltiman, May Land 21231 WENEUSA NAVARRO MD. 31. Date fited (Month, Day, Yeer) 32. Register's Stgnature

was Davidson-Randall

State

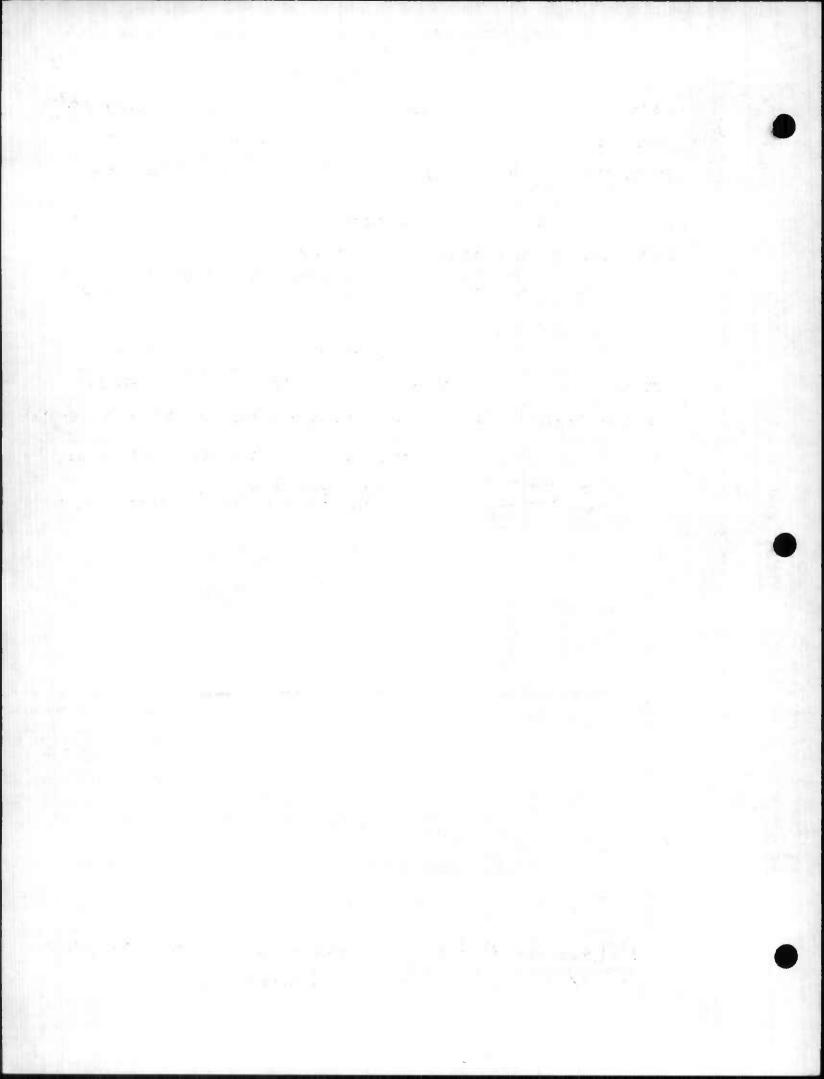
Registrar



State of Maryland / Department of Health and Mental Hygiene

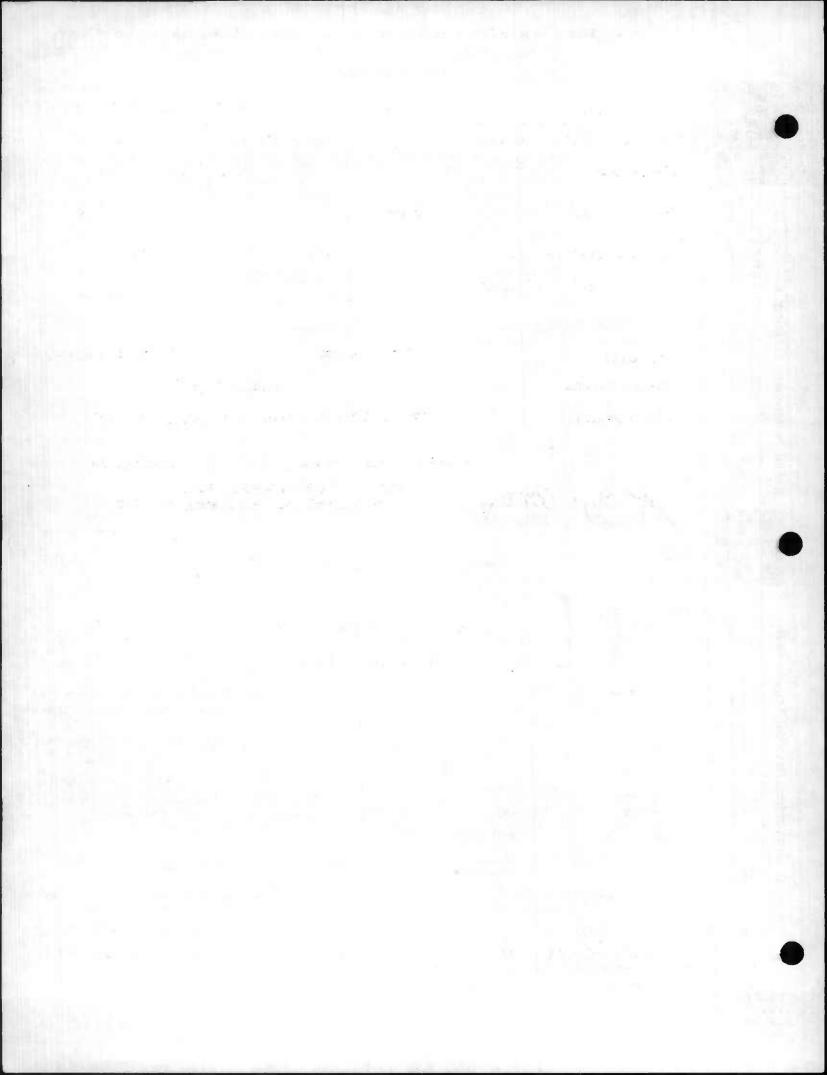
Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** OPPEL YETTA NUV. /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BALTIMORE N/A LEVINDALE If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 8. Dete of Birth (Month, Day, Year) JAN. 5, 1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Months 1 M 25 F RUSSIA 87 Yrs 216-56-6583 Director Usuei Residence of Decedenl with the Maryland 10e. Stete 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Healts Examine man be notified at 10d. inside City Limits 1 Ves 2 □ No Director BALTIMORE N/A 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 2500 W. BELVEDERE AVE., APT. 613 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 — Yes 2 (2) No If Yea, Give Yeer or Detes: 14. Rece - American Indisn, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Stetus 1 Never Merried 2 Merried WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes ♣☐ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (9-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be **EXLER** IDA SCHENKER ISRAEL 2 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
7202 ROCKLAND HILLS DR., APT. 203 BALTO., MD 21209 19e. Informent's Name/Reletionship (Type, Print) MRS. IRENE HIMELFARB (DAUG.) 20b. Pleca of Diaposition (Neme of cemetery, cremetory or other plece)
BETH TFILOH 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 █ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete 11/24/97 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensis 22. Name end Address of Facility SOL LEVINSON & BROS., INC. a 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Pert1. Enter the disease or complications that caus ahock, or heart fellure. List only one cause on each complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest Approximate Interval Betwood **Physician** /Medical immediete Celuse (Finei diseese or condition resulting in deeth) Examiner Examiner Sequentieily list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diaeese or injury thei initiated events resulting in deeth) Last Physician/Medical Due to (or es e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Smillehim þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes sn sutopsy performed? Completed 2 NO 1 ☐ Yea 2 ☐ No Division of Vital funeral director, 25. Wes case referred to medical examiner? 28. Pleca of Deeth (Check only one) To 1 ☐ Yea 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Oulpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturei death. 1 Yes 2 No 2 Accident i or Attend after death Director: / 6 Could not be determined 3 Suicide 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide To the Hospital or within 24 hours af To the Funeral D completely filled i 1 Certifying Physicisn: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 144817 www 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 2434 h Belwedere Rue lejani 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State gedia Davidson-Randallo Registrar WOV 26 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are begible: 5 8 9 0 State of Maryland / Department of Health and Mental Hygiene

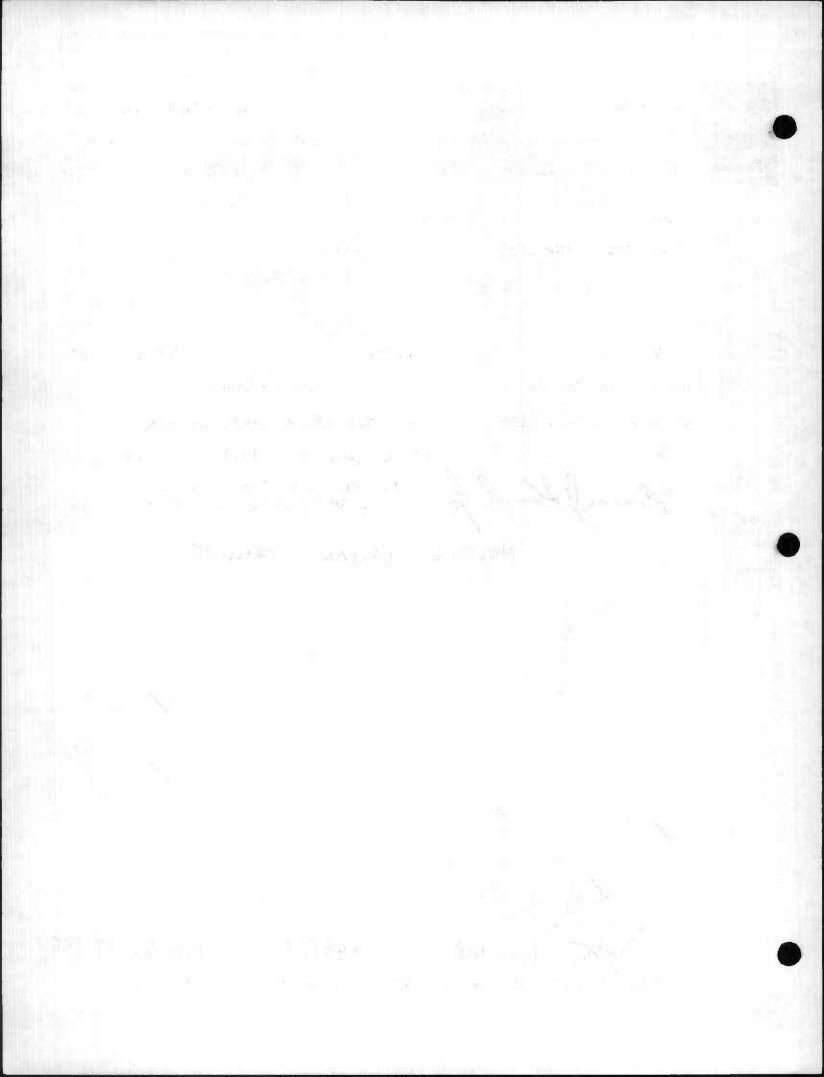
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** RICHARD J. PERRO, JR. NOVEMBER 17, 1997 4:10 P.M. /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 8/22/11.954 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours XXM 2 F 214-64-9889 43 NEVADA Yrs Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at MD 1 ☐ Yes 2 No Director P.G. BOWIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7107 HIGHBRIDGE DRIVE 20720 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours effer c Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iten any Injury or other traumetic event, the Modical Evantment and 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) Coilege (1-4or 5+) LABORER ARUNDEL METALS 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RICHARD J. PERRO, SR. JEAN FOWLER 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DARLENE PERRO - WIFE 7107 HIGHBRIDGE DR., BOWIE, MD 20720 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Cremation 3 Remove from State 4 Donation 5 Other (Specify) LAKEVIEW CEM. 11/21 SYKESVILLE, MD. 21. Signature of Funeral Service 22. Name and Address of Facility
RAYMOND C. FINK FUNERAL HOME 426 CRAIN HWY., SW., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease of complications that cause the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each the Approximate Interval Between Onset end Death **Physician** /Medical MULTIPLE Immediate Cause (Final DRGAN FAILURE diseese or condition resulting in death) Examiner Due to (or es a consequence of) Physician/Medical Examiner certificate be axecuted Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last and burial-trer Due to (or as e consequence of) Box 68760. attanding physician the Due to (or as a consequence of) USe as P.O. Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 8 Completed 24b. Were autopsy findings evallable prior to 24a. Wes en eutopsy performed? completion of cause of death? ate has t 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was cese referred to medical examiner? 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes NO No Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation death. 1 Tyes 2 No To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A complately filled in by the fi 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MJ) Name and eddraw of person who completed cause of death (Item 23a) (Type, Print) DAME. CILEN BRENIE. MO 2106 Cherry . 301 Hastile 31. Dete filed (Month, Day, Year) 32. Registrate Signature Julia Davidson-Handelle NOV 26 1997 Registrar



Physic /Med	ian	rt I.27.28a-f per ! 1. Decedant's Nama (First, Mid Michael D	lla, Last) ouglas	, 20/3/	Raper			Death	2. Data of Month OCT	Reg. No. Death Day 27, 199	3. Tima of Death 7:00 PM.
Exami		4a. Facility Name (If not institution BLUFFS POIN	T	number)				SEVERN	or Location of De IA PARK	Avne	y of Death Arendel
Funera Director		5. Social Sacurity Number 054-54-2500 Usual Rasidance of Decedant	6. Sax 1 → M 2 → F	7. Aga (In	yrs. last birt	rrs. if Un Monti	dar 1 Yaar ns Days		in (Month	Birth Day, Year) 10, 1960	9. Birthplace (Stata or Foraign Country) California
28a-f show	ctor	MD Caro			c. City, Town Presto						10d. Insida City Limits 1 ☐ Yas 2 ☑ No
23a or 28	rai Director	10e. Street and Number 3266 Gallagh	er Road				Zip Coda	21655		10g. Citizan of USA	What Country?
within 72 nours effer death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notitied at	by Funeral	11. Marital Status 1 □ Navar Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	rriad 1 Tas	ecedant Evar Forcas? s 2 XNo Giva Datas:	in U,S.		cedant of lipecify Cub	Hispanic Orlgin? pan, Maxican, Pu Specify:	(Specify Yas or arto Rican, atc.)	No- 14. Rad Bla Specif	ce - Amarican Indian, ck, Whita, atc. 'y: White
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and Mental Hygiene. Is marked other than aumatic event, the M	To Be C	17. Fathar's Nama (First, Middle	, Last) Raper						iama (First, Midd iane	da, Maidan Sumar Bissell	ma)
ges I end 2 should t of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Ralation Douglas Raper/			18	0 Glen	Oban	Drive,	Arnold,	1	12
nent of ant: If it ury or		20a. Mathod of Disposition 1 □ Burlal 2 ☑ Cramation 4 □ Donation 5 □ Other (Specify)		camatar)	Disposition (in cramatory of Crem	or other pla	y 10	Data -31-97		- City or Town, Stata
Departmen Departmen important: any injury once.		21. Signatura of Funaral Sarvice	Be	A		Barra 495 G	ov. I	Kitchie	Hwy., S	verna Pai everna Pa	Funeral Home rk ark, MD 21146
hysician /Medicai Examiner	or .	23e. Part1. Enter the disease, shock, or heart failure. List immediate Causa (Final disease or condition resulting in death)		NARCOTIC	AND CO	OCAINE I	NTOXIC		iac or raspiratory	/ arrest,	Approximate Interval Batween Onset and Deeth
e ettending physician end of for use es the burial-transit	cai Examiner	Saquantially list conditions, if any, leading to Immediata cause. Enter Underlying Cause (Disease or Injury	6	Due	to (or as a c	onsequance o	of):				
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peen s	Completed to								24a. W	as an autopsy normed?	24b. Were autopsy findings available prior to completion of cause of death?
this certificate hes ral director, page 2	o Be Cor	25. Was casa referred to medic axaminar? 1 🛱 Yas 2 □ No	Hospital:	71	• 🗆 = = = = = = = = = = = = = = = = = =		Oti Oti	hor	aath (Check on		107Yas 2□ No IN
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24 hours Funeral	edical C		ng Physician: To the Examiner: On the		knowledge,				ce, and dua to the	na causa(s) and m	
the upper	Σ	29b. Signature and title of certifi	od .				29c. Lican:	sa number		29d. Data signe	ed (Month, Day, Year)

29c. Licansa number O.C.M.E.

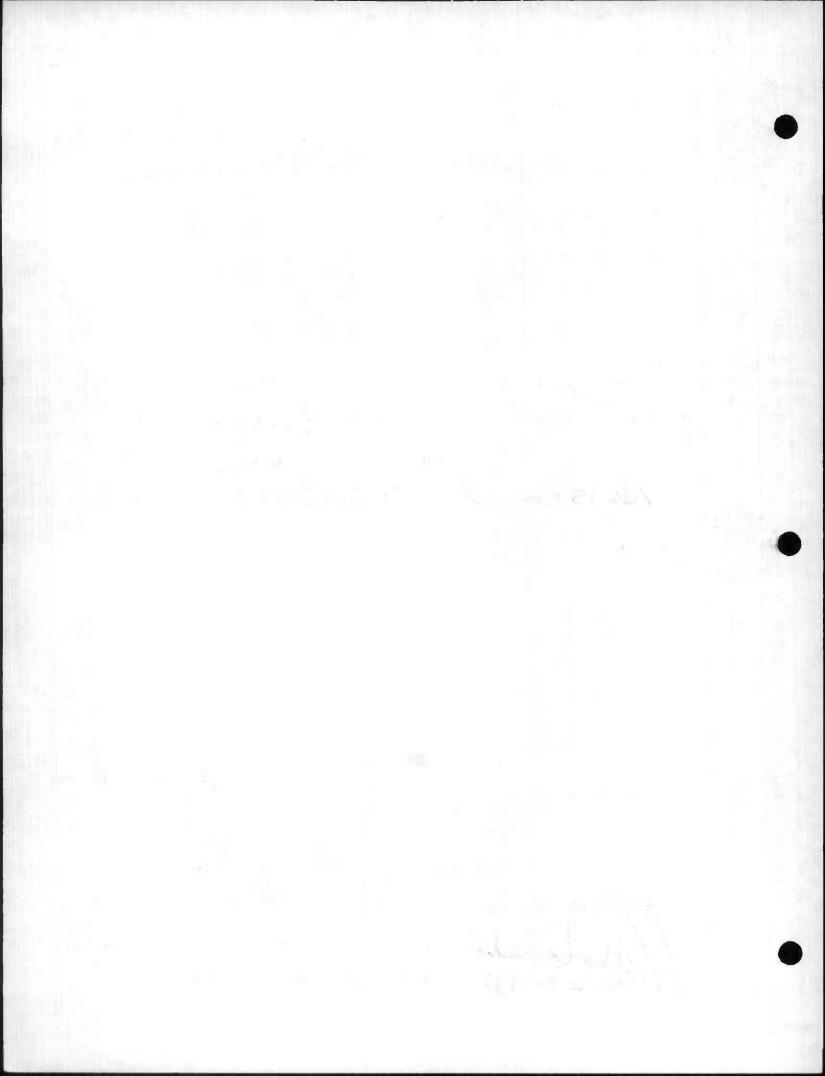
29d. Data signed (Month, Day, Year) 28, 1997 OCT.

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111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filad (Month, Day, Yaar) NOV 06

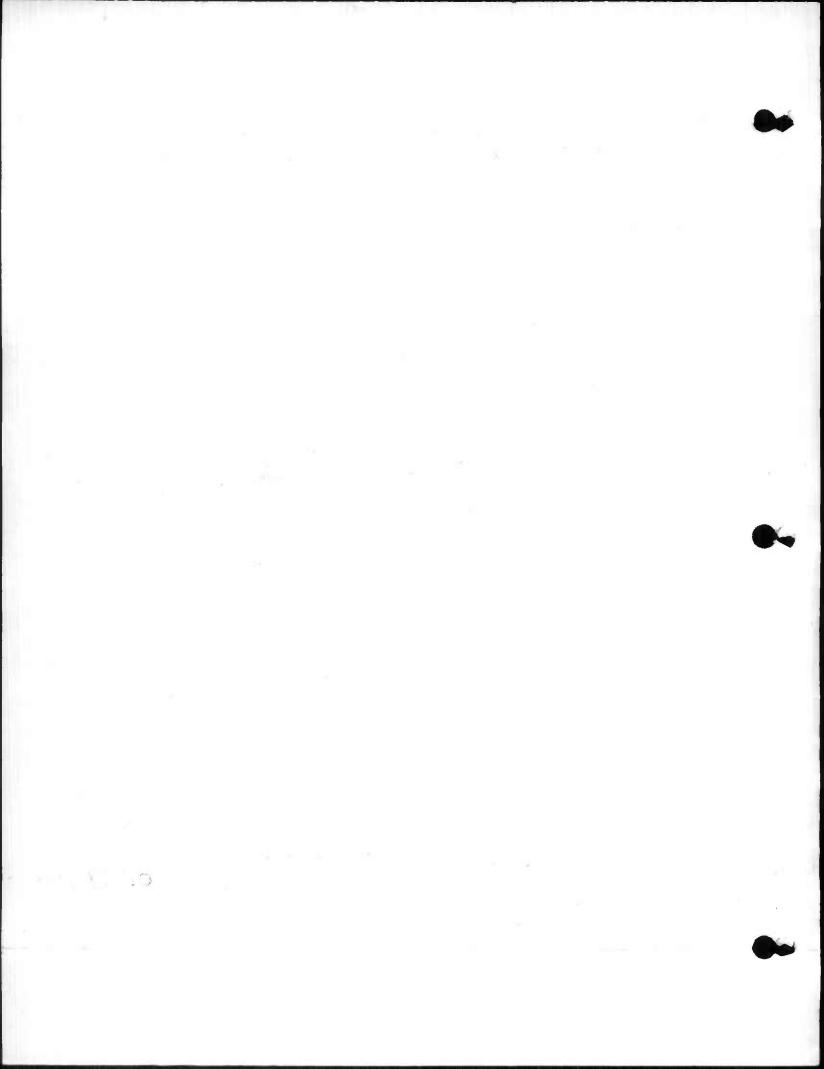
32. Ragistrar's Signatura who Davids



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MAI	RYLAND / D CEF	EPARTME	ENT OF H	EALTH AND DEATH		GIENE G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DE		YEAR	3. TIME OF DEATH
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	TO THE RESIDENCE OF STATE AND ADDRESS OF THE PARTY OF THE	6. SEX 6.	AGE (In yrs. lest bi	MONT	HB DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR (Month, Day,	Year)	Counti	IPLACE (State or Foreign ry)
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DIRECTOR	206 W. Central					alsburg			roli	
REC	10a, STATE 10b, COUNTY		1	loc. CITY, TOV	WN OR LOCAT	ION				10d. INSIDE CITY
	Maryland Caroli	ne		Fe	ederal	sburg				1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER				101.	ZIP CODE				VHAT COUNTRY?
NE	206 W. Central Ave					21632			.S.	
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COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade col	ION moleted)	16a. DECEI	DENT'S USUA	L OCCUPATIO	IN .	16b. KIND	OF BUSINESS/I	NDUSTRY	200
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2	Julia Mills					1 Ave.,				21622
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	21. SIGNATURE OF FUNERAL SERVICE LICEN	10/	_			n Funera	CILITY			
	Homos	Yena	M00295			Somerse		Prince	200 A	21853
	23. PART I. Enter the diseasea, or con ahock, or heart fellure. Lie	nplications that ce	used the deeth		nter the mod	de of dylng, aud	ch as cerdlec or	reaplratory	erreat,	Approximate
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NO N	Sequentially list conditions, b.	DUE TO COR	AS A CONSEQUE	- 4	cri	work	a			
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	552 10 (611	AS A CONSECUE	NGE OF J.						
Ħ	CAUSE (Disease or Injury that initiated evente	DUE TO (OR	AS A CONSEQUE	NCE OF):						
ERI	resulting in death) LAST									
AL C	PART II. Other algolificent conditions of	ontributing to dec	oth but not reed	ulting in the	underlying	r ceuse given in	Part 1. 24a. V	WAS AN AUTOPS	y 24h	WERE AUTOPSY FINDINGS
S	Linensman	car Co	naen	tus		2hs	P	ERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
E I	Waiter	u,	9				'⊔	YES 2 NO		OF DEATH?
ä	DID TOBACCO USE CONTRIB	SUTE TO CAUS	E OF DEATH	YES [] NO [UNCERTAI	N 🗆			
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	28. PLACE C	F DEATH (Ch						
YSI	1 YES 2 KNO 1	☐ Inpatient 2 ☐ ER			IER: Nursing Nome	5 Realdence	8 Other (Speci	(fy)		
	27. MANNER OF DEATN 1 Netural 5 Pending	(Month, Day, Y		8b. TIME OF INJURY	28c. INJU	RK?	28d. DEŞCRIBE	HOW INJURY O	CCURED	
B	2 Accident Investigation	28a. PLACE OF IN	JURY — At home	Jarm street		ES 2 NO	28L LOCATION	Planet and Mount		
8	8 Could not be 4 Nomicide determined	building, stc.	(Specify)		ractory, office		281. LOCATION (City or Town		Her OF PHUNEI P	louie Number,
Ä	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my	knowledne death	occurred at 1	he time date	and alone, and due	to the insurates of	luna santuarra		
COMPLET) and menner as stated.
	29b. SIGNATURE AND PITU OF CERTIFIED	A				29c. LICENSE NUI				(Month, Day, Year)
3B C	19 300	0				DO	11260	W	pV.	24, 1997
5	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE O	FOEATN (ITEM 21	(Type, Print)	DE.	Dr. S	Aus	BURY	m	1 21801
	31. DATE FILED MONV POYZER 1997	32. REQISTRAR'S	SIGNATURE	fandale	,		1 1 300		. 1 %	4, 2,00





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** 11 19 97 ARNETHA ROUNTREE 4.26 am /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner SINAI HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. lest birthdev) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 5 Yrs. 056-20-1372 Usuel Residence of Deceden Director 74 SOUTH CAROLINA 11/20/22 the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 XYes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be U.S. 14. Rece - American Indien, 5906_HIGHGATE DRIVE 21215 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2√2 No Specify: þ 3 Widowed 4 □ Divorced BLACK Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 NURSE MEDICAL 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) MITCHELL SHANNON ELLEN SHIELDS 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) WANDA ABE (DAUGHTER) 2903 LYNDHURST AVE.-BALTIMORE, MD Item 2 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) NAT'L CEMETERY11/24/97 BALTO. MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility ELIZABETH L. PHILLIPS Dectr CFSP 1721-27 N. MONROE ST.-BALTO., MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respirelory errest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medicai Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest physician a Box 68760 Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown 2 P 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ NO 25. Wes case referred to medical exeminer?
1 Yes Yes No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitai: 2 1 Impatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Matural 2 Accident Attending 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide after 6 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e of deeth (Item 23a) (Type, Print)

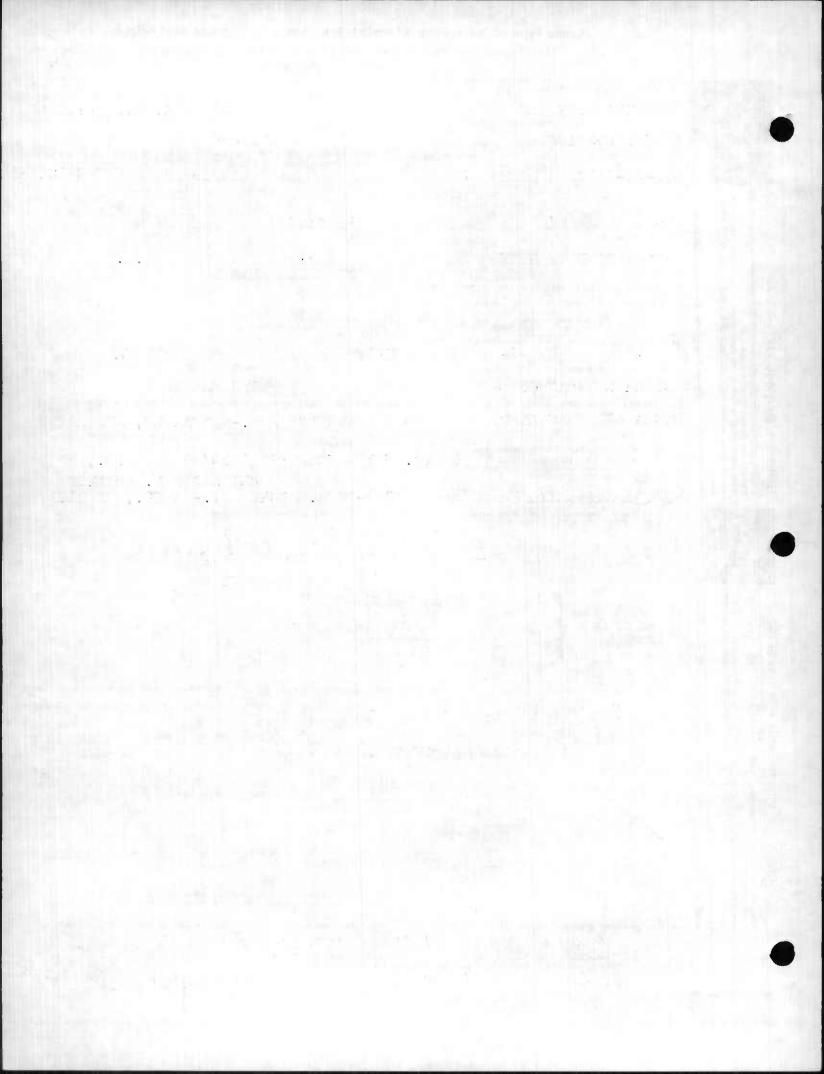
State

Registrar

31. Date filed (Month, Dey, Year)

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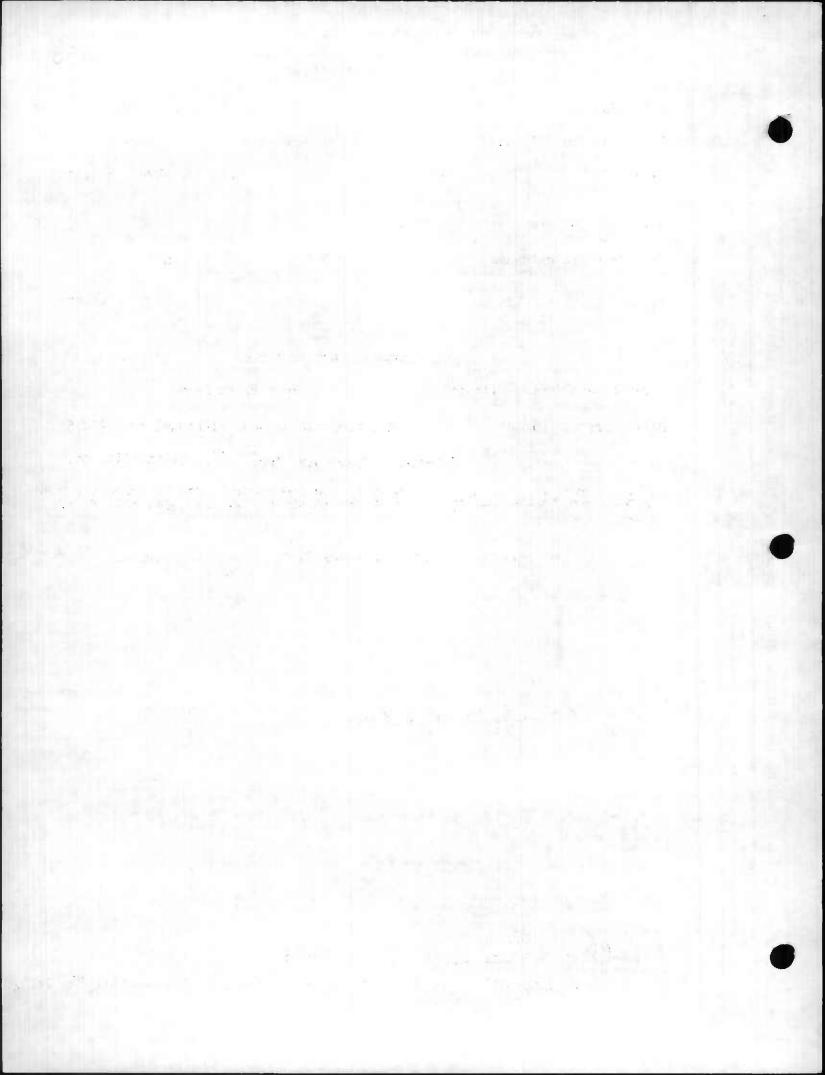
32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 7 35895

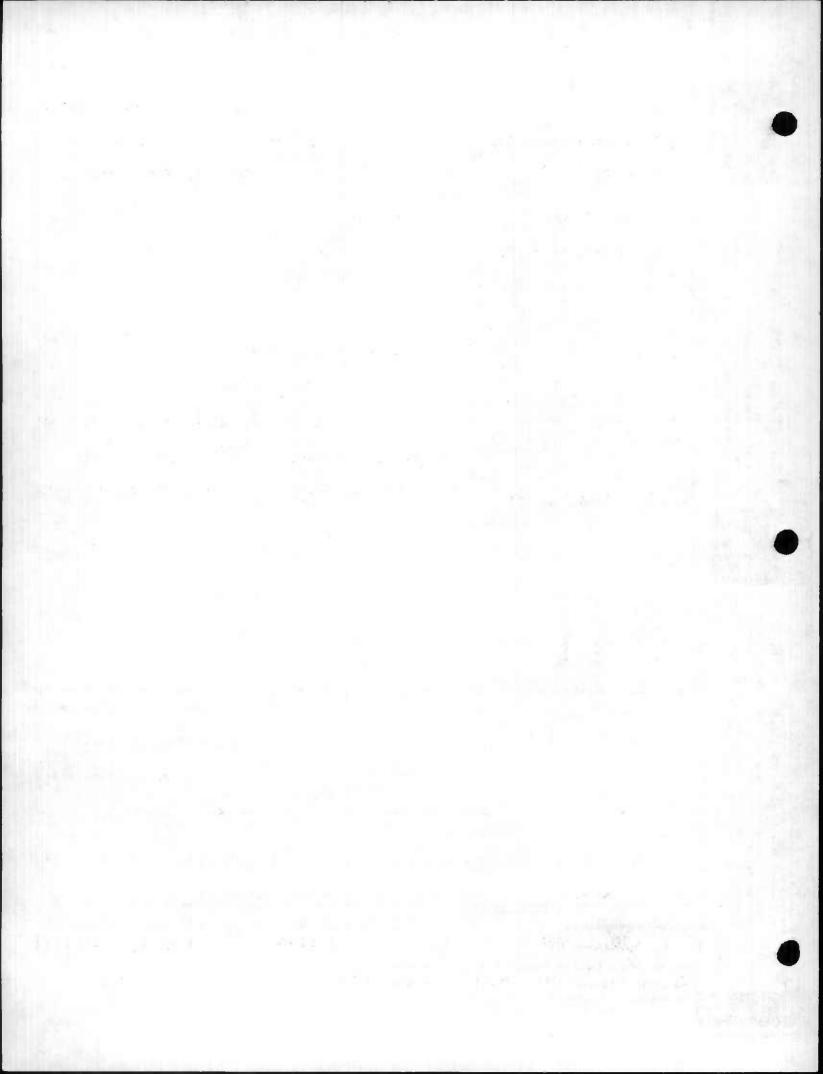
			Cer	tificate of	f Death	R	eg. No.	33030
	1. Decedent's Neme (First, Middle, L.	ast)	Charles			2. Dete of Deet Month	h Dev	3. Time of Death
Physician /Medical	Helen Rumsley					NOV.		997 6:50 AM
Examiner	4e Facility Neme (If not institution, gr	ive street end number)			4b. City, Town, or	Location of Deeth	4c. County	of Death
	6464 Beechfield	l Avenue			Elkrid	ge	How	ard
uneral irector		Sex 7. Age (in)	73 Yrs.	Months Dey			Year) , 1924	9. Birthpleca (Stete or Foreign Country) Maryland
ahow or	Usuel Residence of Decedent							
Funeral Director	10e. Stete 10b. County	100.	City, Town or Lo	cation				10d. Inside City Limits
cto	Md. Howa	ird [Elkridge					1 Yes 2 No
Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	Vhet Country?
8	6464 Beechfield	Avenue		210			USA	
Funeral	11. Maritel Stetus	12. Was Decedent Ever I Armed Forces?	n U,S. 13. \	Wes Decedent of	Hispenic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		a - American Indien, k, White, etc.
by	1 Never Memed 2 Merried 3 XWidowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:		1□ Yes 2□XN			Specify	
ted	15. Decedent's E	Education	16e. Deced	dent's Usuel Occ	upetion	orkina	16b. Kind of Bu	siness/Industry
Completed	(Specify only highest go	College (1-4or 5+)	life. I	DO NOT use reti	e during most of wo	nknig		
NO.	9		Cosm	etic Fac	ctory Worl	ker	Cosme	tics
Be	17. Fether's Neme (First, Middle, Las	1)				me (First, Middle, I	Maiden Sumem	Θ)
10	George Washir	gton Wilhelm			Mary I	Ellen Mas	on	
	19e. Informent's Name/Reletionship	(Type, Print)	19b. Mailir	ng Address (Stre	et end Number or R	turel Route Number	City or Town,	State, Zip Code)
	Delma Gordon -	niece	6464	Beechfi	eld Avenu	Je, Elkri	dae, Md	. 21075
	20e. Method of Disposition		b. Plece of Dispo	sition (Neme of metory or other p	laca)	Dete	20c. Location -	City or Town, State
	1 Burlel 2 Cremetion 3 4 Donetion 5 Other (Spec		nesapeak		cory, Inc	11/24/97	Beltsvi	lle, Md.
ò	21. Signeture of Funeral Service Lica			2. Neme end Add				THE REST
	4 E/ D1	001	Ga	ry L. Ka	oufman Fu	neral_Hom	e at Me	adowridge MP
	23e. Park Er er the diseese, or cor shock, or heert failure. List only	unlications that course white	- /2	50 Washi	ington BI	vd., Elkr	idge, M	d. 21075 Approximete
al er	Immediale Cause (Final disease or condition resulting in deeth)	e.Motostoti	SQ WU to (or es a consec	quence of):	all	ng c	anger	3 month
Examiner	Sequentially list conditions	bDue 1	to (or es e consec	uence of):				
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury							
edical	thet initieted events resulting in death) Lest	C. Due t	o (or es a conseq	uence of):				
5	resulting in deatiny cost							
ar.	Company of the last of the las	d						
10	Pert ii. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause	given in Pert I.	23b. Did to	bacco use cor	ntribute to the ceuse of death?
by Physician/I	COPD rec	unest a	SPIVO	Lyn		1)24	es 2 No	3 Probably 4 Unknown
Completed b			V			24a. Wes a perform		24b. Were eutopsy findings avelleble prior to completion of cause
id i								of death?
ပိ						1 🗆 Yı	es 25Ho	1 Yes 2 No
Be	25. Was case referred to medical examiner?	t le se ite le				eth (Check only or	ne)	
To	1 Yes 2 No		2 ER/Outpetier	I SLI DOA	Other: 4 Nursing	1	ence 6 Othe	
on:	27. Menner of Deeth 1 SAlaturel 5 Pending	28a. Dete of Injury (Month, Day Yea	r) 28b. Time of Injury	W		28d. Describe h	ow injury occurr	790
ficati	2 Accident investigation 3 Suicide 6 Could not determine	be One Place of Injune	At home, ferm, str		Yes 2 No	28f. Location (S	treet and Numb	per or Rurel Route Number,
Certification:	4 Homicide	building, etc. (Sp	pecify)			City or Town	n, Stete)	
edicai		hysicien: To the best of my miner: On the basis of exen and menner stated.						
Medical Certificati	29b. Signet and title of certifier	. 0		29c. Lice	nse number	2	9d. Date signer	d (Month, Dey, Year)
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	and I	met -		193	0/82	Po.	Novem	24, 1971
	30. Name end eddress of person who	completed cause of deeth	(Item 23e) (Type,	derick	-Rd. Su	te 110 C	Ano	ville med ricz
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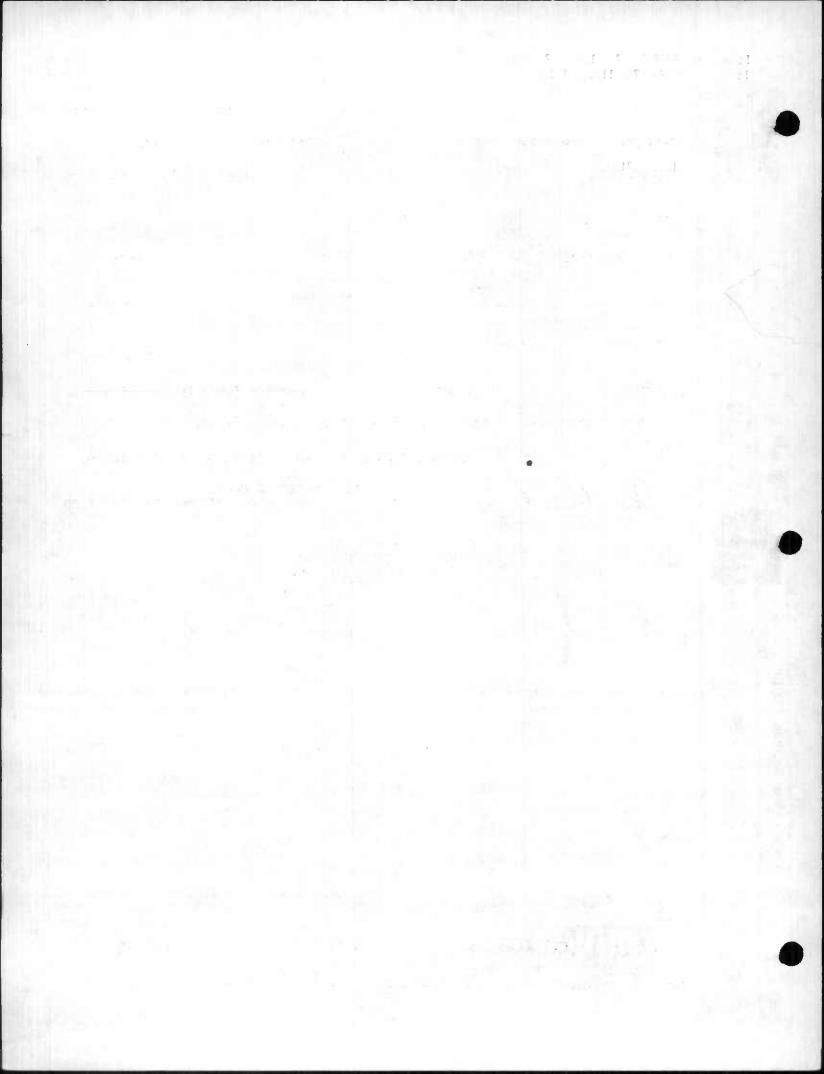


State of Maryland / Department of Health and Mental Hygiene 97 3589

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г	5.	Social Security N	The second secon	6. Sax	-	7. Aga (In yr	s. last birthday)		dar 1 Yaar	If Under 24	Hrs. 8. Data of E		Howa		(State or Foraid
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		0a. Stete	10b. County			10c. (City, Town or Lo	ocation						10d.	Insida City Limit
cto		Md.	Howa	rd		E	llicot	t Cit	ty						1□Yas 2NN
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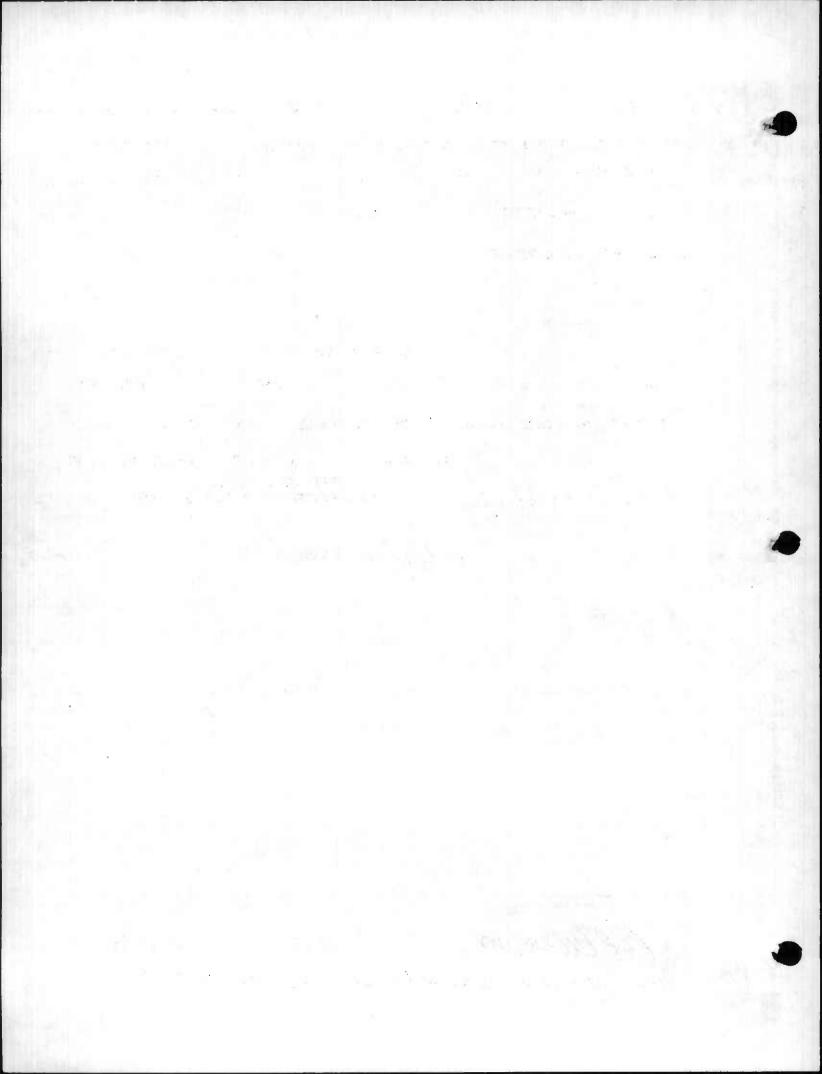


4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death Apt J Baltimore N/A Funder 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplaca (State or Fore Country) 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10d. Inside City Lim			 Decedent's Nama (First, Middla 	, Last)	-11-			of Death	2. Data of Daa			3. Tima of Daath
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Sol Levinson & Bros 8900 Reisteratown Rd_Pikesville, MD 21208 Approximate Ap					rom Stata				11/23/97	Randa:	llstow	m, MD
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Director	10e. Street and Number 7233 BROOKFA	LLS TERRAC	E		10f. Zip Code	21209		10g. Citizen of V	What Countr	y?
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To Be C	17. Fathar's Name (First, Middle, PAUL	Last) HERMA	N		DNEY			, Maiden Surnam		KY
-	19a. Informant's Name/Reletions	nip (Type, Print)		19b. Meilin	g Address (Street	and Number or R	ural Route Numb	er, City or Town,	State, Zip C	Code)
	SUSAN COHEN S 20a. Method of Disposition 1 🕅 Burlal 2 □ Cramation		20b. Pla	ce of Dispo	BROOKFA sition (Name of netory or other plan		RACE B.	ALTO., M 20c. Location -		209 n, State
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an/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a	Due to (or a	s e conseq		oncor				S maths
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Certification: To	exeminar? 1 Yes 2 No 27. Manner of Death Matural 5 Pending 2 Accident investig 3 Sulcide 6 Could n	ation 28a. Date of (Month)	Injury , Dey Year)	NOutpatient Bb. Time of Injury	28c. Injur Wor 1	er: 4 Nursing I	foma 5 ☐ Resi 28d. Describe	dence 6 Other	ed	Double Aliem har
	4 Homicide determi	Physician: To the b	g, etc. (Specify)		eet, factory, office	an data and also	City or To	wn, State)		
Medical	(Check only one) Madical E	caminer: On the bas and manne	er stated.	end/or inv	estigation, in my o	pinion, death occu	irred at the time,	cause(s) and maidete and place, a 29d. Date signed	ind due to the indicate of the	ne cause(s)
	30. Name and address of person v			3e) (Type, F			one mo			
State istrar	31. Data filed (Month, Dey, Year)	32. Re	gletar's Signatur	dron-A	Andell					

A



no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

wie Davidson

111 Penn Street, Baltimore, Maryland 21201

Mandell

State

30. Name

M

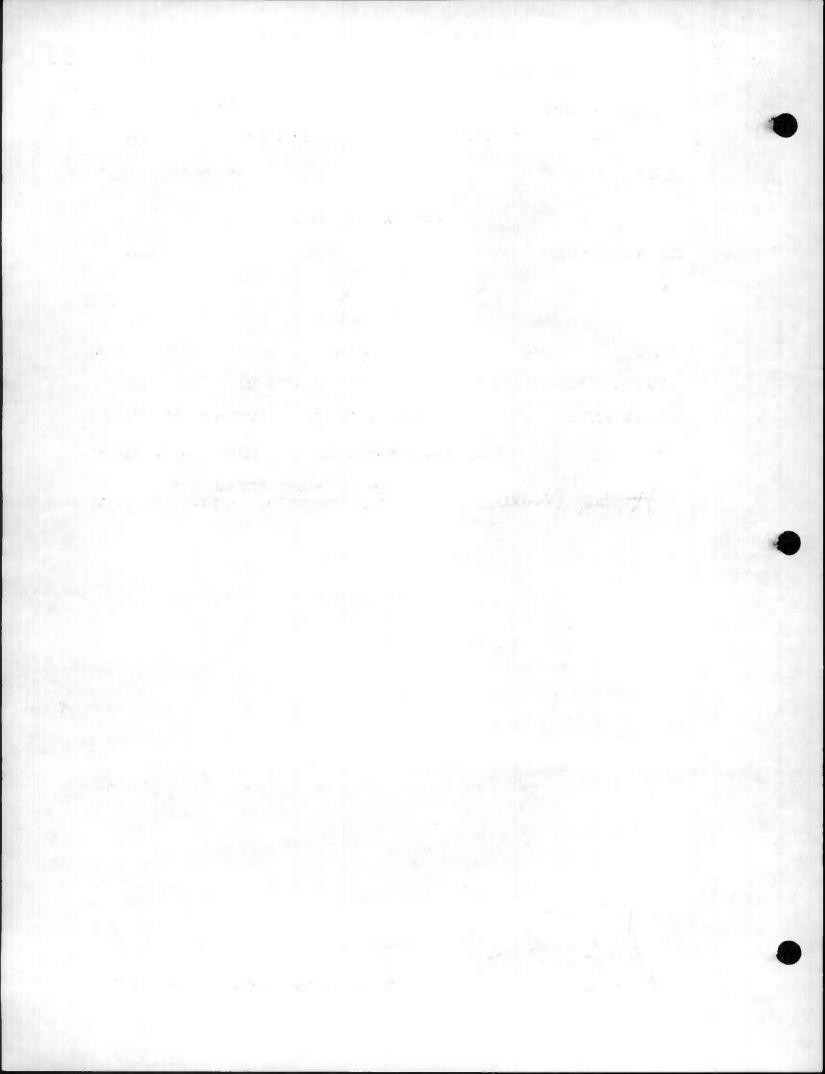
31. Dete filed (Month, Day, Year)

10

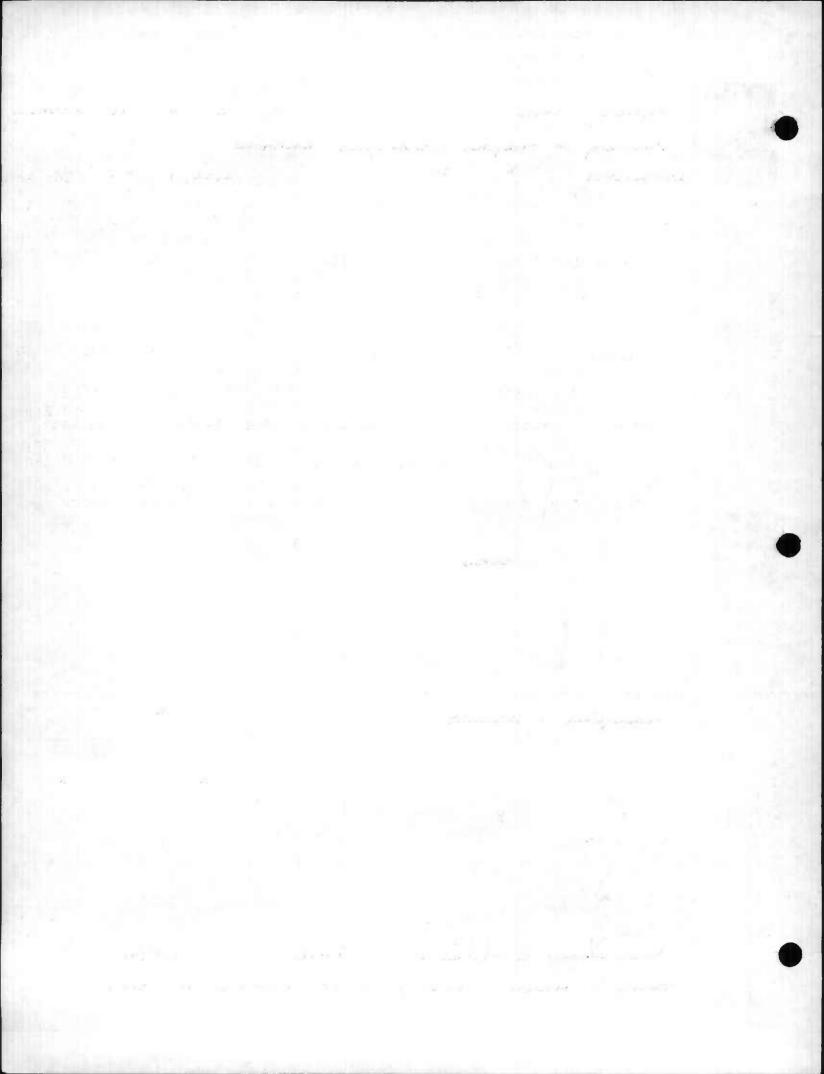
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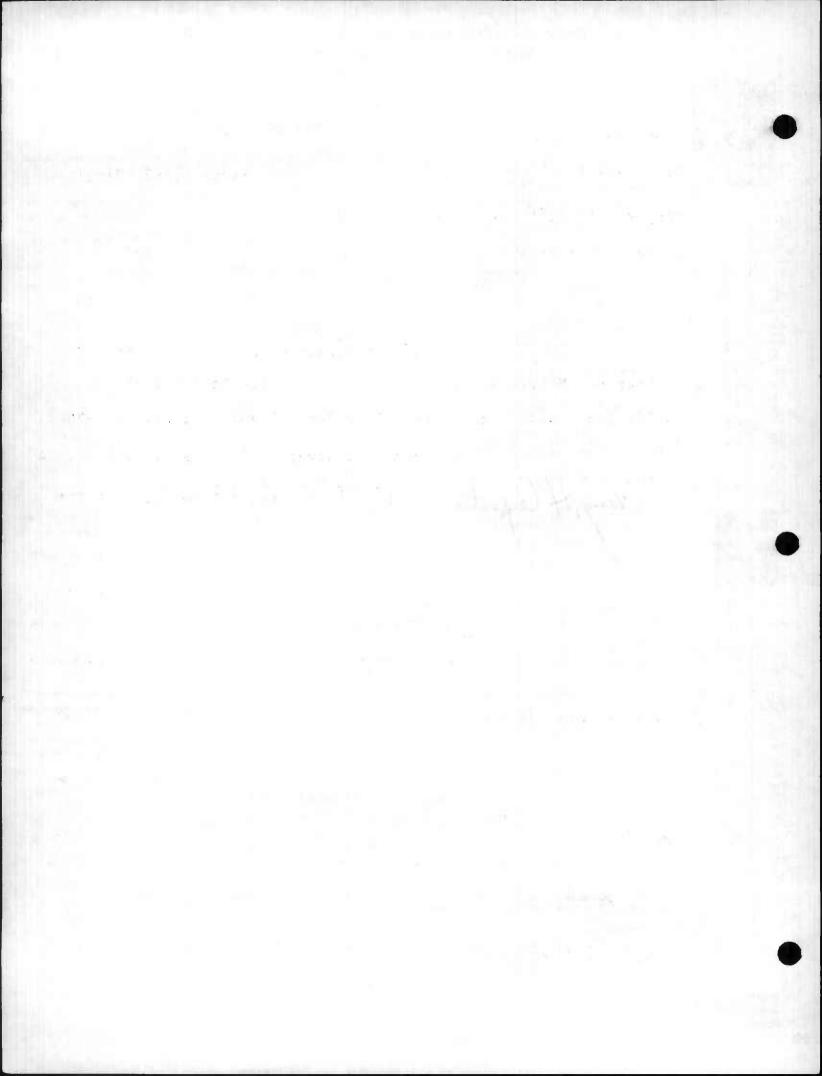
Registrar



	1	. Decedant's Nam	e (First, Middle	Last)			rtificate of		2. Dete of D	Reg. No.		3. Time of Dee		
ian									Month	Dey 20	Yeer			
ical ner		a. Fecility Neme (give street end numb	oer)			4b. City, Town, or	Location of Dae		of Deeth	10:08		
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5						Baltim					10	0d. Inside City Li ★ Yes 2 ☐		
Director	-	Md.	NA		1	Baltim								
급	[0e. Street end Nui	noer				10f. Zip Code			10g. Citizen of	What Coun	try?		
Funeral			righto	n Street	oot Ever le I	16 12 1	2121	•• /-	Pagait. Van av N	USA	e - America	an Indian		
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by F		1 Never Marr		ed 1 Tes 2 If Yes, Give Yeer or Dete	46		1 ☐ Yes 21 No	Specify:		Specif	y: B1	ack		
Pa			15. Decedant's			16e. Deced	dent's Usuel Occi	upation		16b. Kind of B				
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BeC		7. Father's Neme	(First, Middle, L	ast)				18. Mothar's Na	ma (First, Middle	a, Ma <i>iden S</i> umen	ne)			
To		Frank	М.	Blake				Eliza				rris		
		19a. Informent's Ne	me/Reletionsh	ip (Type, Print)		19b. Meillr	ng Address (Stree	et end Number or F	ural Routa Num	ber, City or Town,	State, Zip	Code) 212		
		Debora	h	Parker				ton Str	eet Bai	ltimore	, Ma	ryland		
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		4 Donetion	5 Other (Spi	BCILD	Ga	arriso	n Fore	st VA C	em. 11-	26-97	Owin	gs Mil		
	1	Signature of Fu	need Service Li	consee		22	2. Name and Add	ress of Facility	al+im/	ore. Ma	rula	nd 212		
		N/- //-	- h	W /a							re, Maryland			
	١.	Xala	111	A Bru	7	W	M.C. M	arch FH	1101 1	E. Nort	h Av	enue		
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						Ce	rtificate o	f Death		Reg. No.		
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	Physic /Medi		Lawrence				Spady		Hoven	ber 23 11	997	2,38 m, m
	Exami		4e. Facility Neme (If not institution, gi	NS HOSP	TAL			BALTIM	RE CITY	th 4c. County		
1	Funerai Director		5. Social Security Number 6. 231 - 38 - 5791	Sex 1 M 2□ F	7. Age (In yrs.	last birthdey, 66 Yrs.	Months Dey		Hrs. 8. Date of B (Month, D March		O Dist	plece (Stete or Foreign htty) rginia
	Meryland -f show	tor	Usuel Residence of Decedent 10a. Stete 10b. County Virginia ISIE	of Count		ty, Town or Lo Batte	ocation ry Park	<			1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	s with the	il Director	10e. Street end Number 10296 Park Str		J		10f. Zip Code	23304		10g. Citizen of		ntry?
020	n 72 hours effar death with the Menyland "natural", or items 23a or 28a-f show poicel Examinet must be notified at	by Funeral	11. Marital Status 1 □ Never Merried 2X□Merried 3 □ Widowed 4 □ Divorced	12. Wes Dece Armed For 1 Tes If Yes, Giv Yeer or Da	rces? ≱⊡∜ No e	l,S. 13.	Was Decedent of If Yes, specify Control of Yes 2 🗓 N		17 (Specify Yes or Noverto Ricen, etc.)		e - Americ ck, White, /: Wh	
21215-0020	be filed within 72 ho ital Hygiena. d other than "natur svent, the Modical	Completed	15. Decedent's Elementery/Secondery (0-12)	ducation ede completed) College (1	-4or 5+)	(Give	dent's Usuel Occ e kind of work dor DO NOT use peti Ger of ral Cor	ne during most o	f working	16b. Kind of B		
		To Be Co	17. Fether's Neme (First, Middle, Las Lawrence Me	,	pady,		141 601	18. Mother's	Neme (First, Middl Zabeth	e, Maiden Sumen	10)	
Maryland	ges 1 and 2 should be t of Health and Menta If Item 27 is marked or or other traumstic sv	I	19e. informent's Name/Relationship Mollie Sue Kod	(Type, Print) ontz Sp	ady-W	i fe	ing Address (Stre	etend Number of	or Rurel Route Num	ber, City or Town, ttery,	Stete, Zip	2 3 3 0 4
Baltimore,	permit. Peges 1 and 3 Department of Health Important: If Item 27 I any Injury or other tr. 9068.		20a. Method of Disposition 1 🔀 Burlal 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Speci			cem etery, cre	osition (Name of matory or other p Park (olace) Cemeter	Date 7 11/26	Batter		
Balti	permit. DepartmImports any Inju		21. Signeture of Funerel Service Lice	ntee O	1	2	Name end Ado Burgee- 3631 Fa	ress of Facility Henss	Funeral ad Balt	Home imore.	MD	21211
	Physician		23a. Pert1. Enter the disease, or con shock, or heen feilure. List only	pplications Mat co one ceus on e	sused the deet ech line.					,		Approximate Interval Between Onset and Death
	/Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)	a S	2 ps 5 5	or as a conse	quence of):					72 hours
-	D #	iner		R	enal							1 week
90,	oe exacute cien and ouriel-trans	I Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	0.		or es e conse		13		31		72 hours
x 68760,	thet the death certificete be executed ed by the attending physicien and detached for use es the buriel-transit	Medical	thet initieted events resulting in deeth) Lest		Due to (o	or es e consec	quence of): eritoni	415				72 hours
Bo	attar 1 for u	Physician/	Date On the State of the State						1			
P.O.	the d	hysi	Pert II. Other significant conditions of					given in Pert I.				the cause of death?
ď.	signed b	by P	Head and	Nec	K C	uncer				Yee 2□ No	3 10	bably 4 Unknown
Division of Vital Records,	requ shoul	Completed t							24e. We	s en eutopsy lormed?	av	ere autopsy findings allable prior to mpletion of cause death?
æ	0 - 0	mo							10	Yes 2 No		Yes 2⊠No
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>	Physician: this certific ral director.	ToE	exeminer? 1 Yes 2 No	Hospital:	patient 2	ER/Outpetle	nt 3 DOA	Whor	ng Home 5□Res		er (Specil	v)
o uoi	Attending Physician: ir death. sctor: After this certific by tha funeral director.		27. Menner of Deeth 1 Netural 5 Pending 2 Accident Investigation	28e. Dete o (Monti		28b. Time of Injury	of 28c. In		28d. Describe	how Injury occur		
Divis	frac frac n by	Certification:	3 Suicide 6 Could not be determined	28e. Place	of injury - At hig, etc. (Specif	ome, ferm, st	reet, factory, offic	е		(Street end Numb own, Stete)	per or Rure	el Route Number,
	To the Hospital or Att within 24 hours eftar d To the Funeral Diract completaly filled in by	edical	29a. Certifier (Check only one) 1 Certifying Pt 2 Madical Exam	nyeiclan: To the l niner: On the be end menn	sis of exemine	wledge, deet tion end/or In	h occurred et the evestigetion, in my	time, dete end p opinion, deeth	olece, end due to the occurred et the time	e ceuse(s) end mo , dete end plece,	and due to	teted. the ceuse(s)
N.	To t com	M	29b. Signeture and title of certifier	AD	m.D	ı		se number	0	Hovenb		
1,	T)			pkons t	tospit	al	Print) Balt		Marylan	d		
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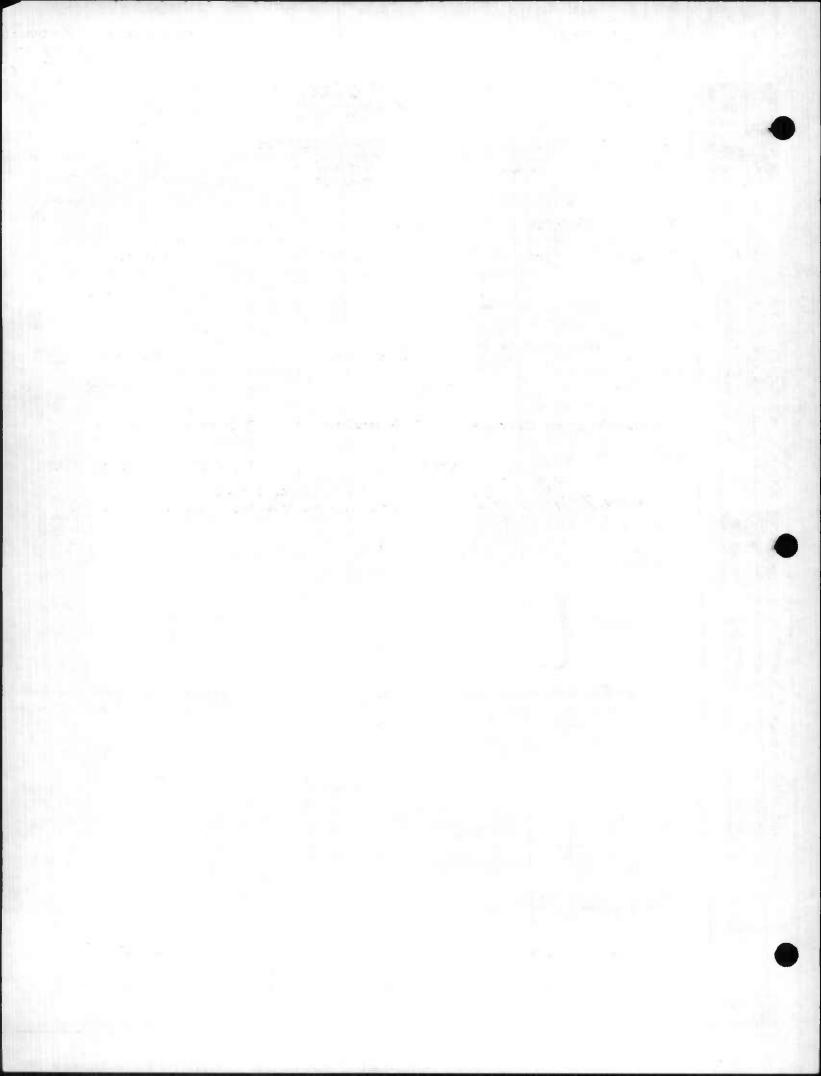
State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month 21, **Physician** Adele Siskind Nov 2:55 PM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 3305 Janellen Drive Baltimore Baltimore If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Data of Birth (Month, Dey, Year) **Funeral** Days Months 1□ M 2√X 128-24-7745 Yrs **Director** 93 Aug 15, 1904 Connecticut Usual Rasidance of Decadant the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show rai', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yas 2 ☐ No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 238 3305 Janellen Drive 21208 U.S.A. Funeral lterne. 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amaricen Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 ia marked other than "natural", or item any injury or other traumatic event, the Medical Experiment ARCS. Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas XXNo Specify White Specify: þ 3€Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Be Abraham Crooq Deane Markoff 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3305 Janellen Drive, Baltimore, MD 21208 Mrs Deane S Sevel (Daughter) 20b. Piace of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Oheb Shalom 11/24/97 Reisterstown, MD 21. Signature of Fynaral Sarvice Licanses 22. Nama and Addrass of Facility Sol Levinson & Bros 8900 Reisterstown Rd, Pikesville, MD21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reshock, or heart tailure. List only one ceuse on each line. Approximete Intarval Between Onsat and Death **Physician** /Medical Immediete Causa (Final disaasa or condition rasulting in deeth) **Examiner** Dua to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificale be executed Sequantially list conditions, if any, leading to immadiate ceusa. Enter Underlying Cause (Disease or Injury that Initiated evants rasulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) attending use for signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ been si 24b. Wara autopsy findings availabla prior to completion of ceusa of daath? Completed 24a. Was an autopsy parformed? page 2 1 Yas 2 No 1 Yas 2 No certificate al or Attanding Physician: The safter death.

I Director: After this certificated in by the funeral director, pages of the physician death. Be 25. Wes cesa ratarred to medicel exeminer? 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Residence 6 □Other (Specify) Certification: To 1 ☐ Yas 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Daath 28a. Dete of Injury (Month, Dev Year) 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accident 6 Could not be 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 4 - Homicide To the Mospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To tha best of my knowledge, death occurred et tha tima, data and place, and dua to tha causa(s) and mannar as stated. cal 29a, Cartiflar 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Neme endaddrass of parson who complated ceusa of death (Item 23a) (Type, Print)

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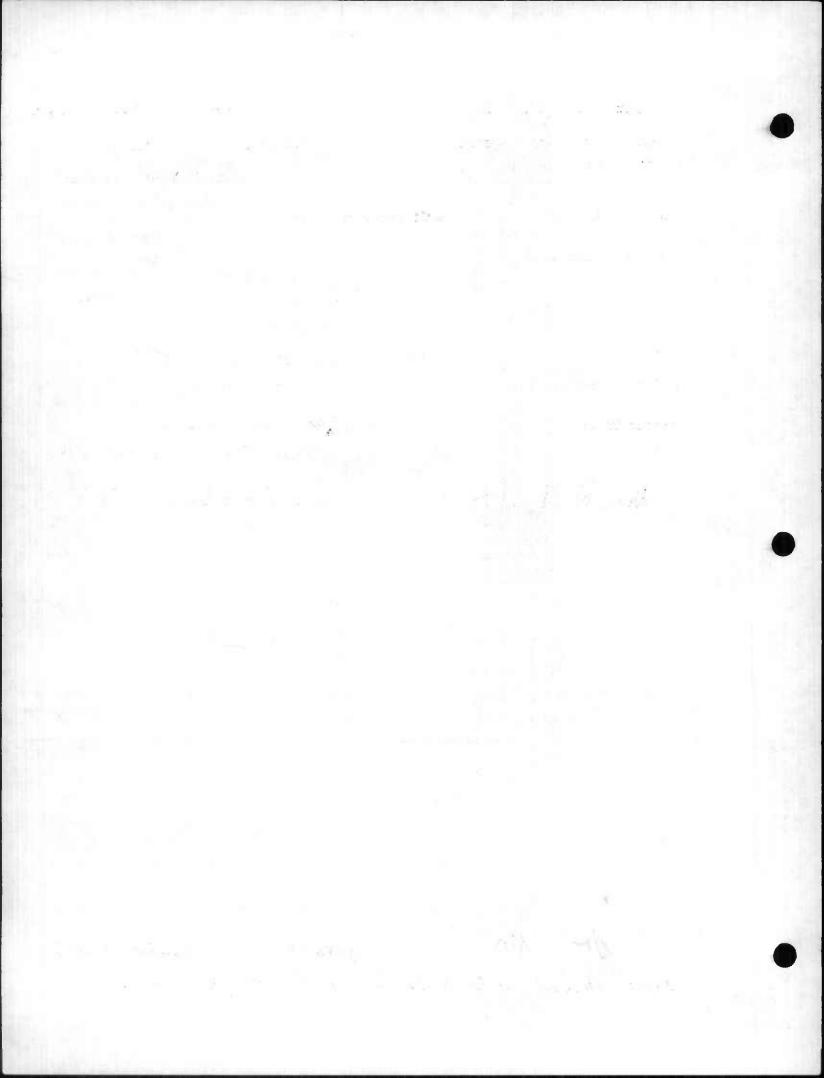


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Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 1997 **Physician** 19, Milton Elmore Smith, Jr. Nov. 11:45 AM /Medicai 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fallston General Hospital Fallston Harford if Under 1 Yeer Months Deys If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys M 2□F Yrs Director June 24, 1910 Maryland Usual Residence of Decedent 10a. Stete 10c. City, Town or Location the Marylan r 28a-f show 10d, inside City Limits MD Harford White Hall 1 ☐ Yes & No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 2929 W. Church Lane 21161 Funeral IISA chaath permit. Pages 1 and 2 should be filed within 72 hours after dea.
Department of Health and Mental Hygienus.
Important if flem 27 is married other the.
any injury or other trauser. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stefus 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2XXNo if Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2X No White þ Specify: 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Farming 10 Farmer/Owner/Operator 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumeme) Be Milton E. Smith, Sr. Bettye Hughes 2 19e. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 116 Cherry Rd. Street, Md. 21154

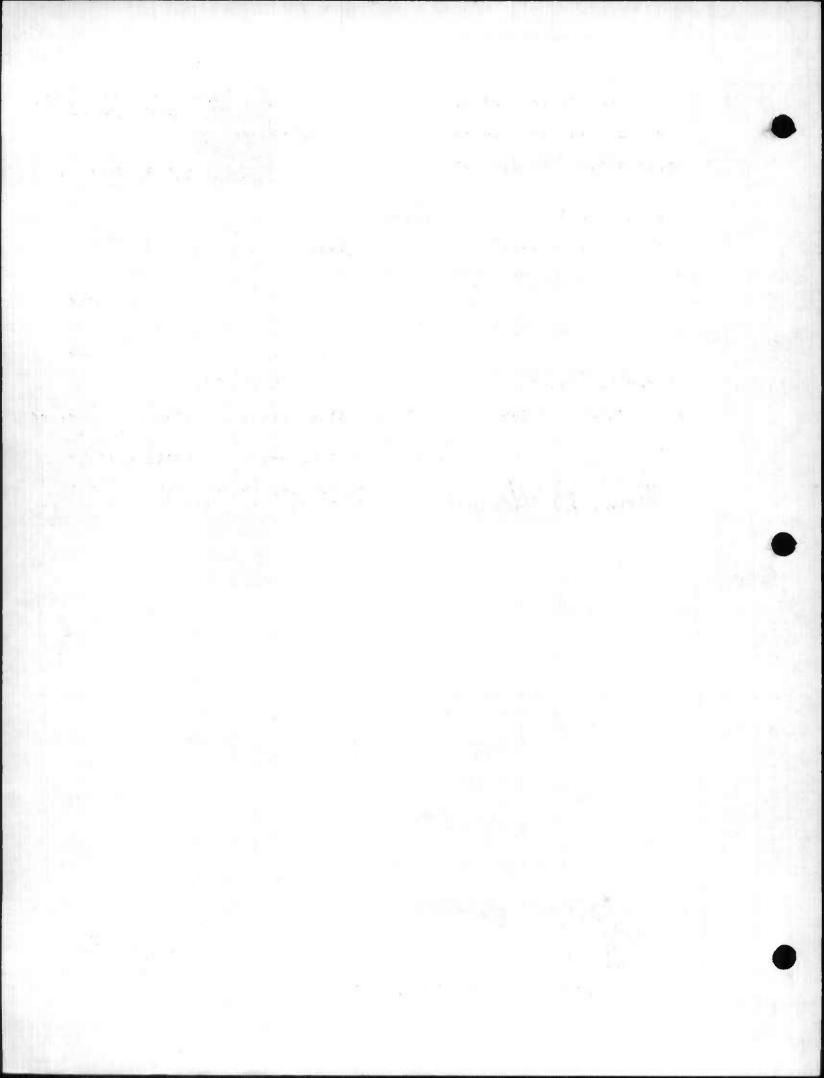
20b. Plece of Disposition (Name of Date 20c. Loca Harriet Crowl Dete 20c. Location - City or Town, Stete 11/22/97 Pylesville, M 20e. Method of Disposition cemetery, cremetory or other place)
St. Paul's United Methodist Cemetery ¥⊠ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete Pylesville, Md. 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Fecility 21, Signeture of Funeral Service Licenses J. J. Hartenstein Mortuary, Inc. 23a Pert1. Enter the disease, or complications that coulsed the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one hause of each line. 19 S. Main St., Stewartstown, Pa. 17363 Physician tmmedlete Cause (Finel diseese or condition resulting in death) /Medical Prenmonia 1 day Examiner Due to (or es e consequance of): Examiner law requires that the death certificate be executed physician and the burial-trans Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 88 esn ò Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Asthmu signed t Records, by 24b. Ware autopsy findings evallable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen has page 2 certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital • Hospital or Attending Physician: 24 hours efter death. • Funeral Director: After this centific funeral director, 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 28e. Dete of injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c. injury ef Work? 28d. Describe how injury occurred 1 WNeturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined To the Hospital or Atta within 24 hours efter de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida Certifying Physician: To the best of my knowledga, daath occurred et the tima, data and place, and dua to tha causa(s) end mannar as stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, daeth occurred et the time, dete end place, and dua to tha cause(s) end menner stated. Medical 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Novamber 19, 1997 30. Neme and address of person who completed causa of daath (item 23a) (Type, Print) Bel Air Marylend 21014 2 Worth HUSWell A-renu-1 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State whie Davidson NOV 26 1997 Registrar



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ı	Physic		1. Decedent's Ne <i>ma (First, Middia, La</i> Rose Mar					2. Dete of Death Month	Dey 9 Ye	3. Time of Death
	/Medi Examii		4e. Fecility Nama (If not institution, giv Union Memori	e street and number) al Hospital		-	4b. City, Town, or Lo Baltimo	cation of Deeth	4c. County of E	Death A
	Funeral Director		5. Social Security Number 6. S	ех □ м 2ДX= 7. Age (In ул 9 7	rs. last birthdey) Yrs.	If Under 1 Year Months Deys	Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day U.G. 20	Year) 9.	Birthplace (Stata or Foreign Country) West Virgin
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020	n 72 hours after death with the Maryland "natural", or hems 23a or 28a-f ahow solical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Nevar Married 2 Merried 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Yaer or Detas:		/as Decedent of P Yas, specify Cub ☐ Yas 2 No	Hispenic Origin? (Spe an, Maxican, Puerto I Specify:	cify Yas or No- Rican, atc.)		Amarican Indian, White, etc. White
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1212	ied with lygiene. ner than	Comp	Eiementery/Secondary (0-12)	Collage (1-4or 5+)		memakeı	r			n Home
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Man	od 2 sho lth and P 17 is ma traume		19a. Informant's Neme/Reletionship (ack ledder	Type, Print) Son	19b Malling	Address (Street	t and Number or Rura nd Avenue	Poute Number.	City or Town, Ste	Maryland
Baltimore,	semit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene mportant: If Item 27 is marked other than "natural", nay fillury or other traumatic event, it at Modical Exa- 2008.		20a. Method of Disposition 1 \(\times \) Burial 2 \(\times \) Cremetion 3 \(\times \) 4 \(\times \) Donation 5 \(\times \) Other (Specification 1)	Removel from State		etory or other ple	emetery		Oc. Location - City	
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	that the death cert ed by the attendin detached for use	Physician/M	Part II. Other eignificant conditions of	ontributing to death but not re	esulting in the unc	dartying causa gh	ven in Pert I.	23b. Did tot	sacco use contrib	oute to the cause of death?
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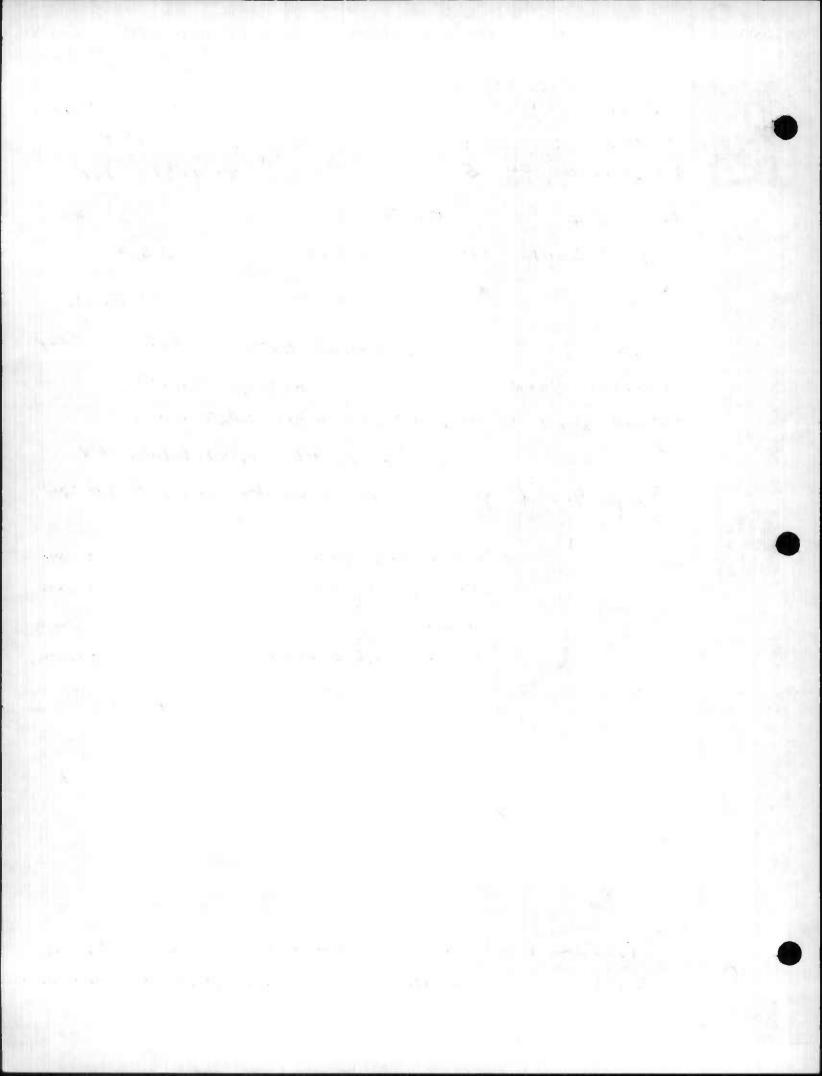
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0	30. Nama and address of person who		of death (Itam 23a) (T		O NORTH L	JOLFE STR	LET, BAI	LTIMORE,	MARYLAN

State Registrar

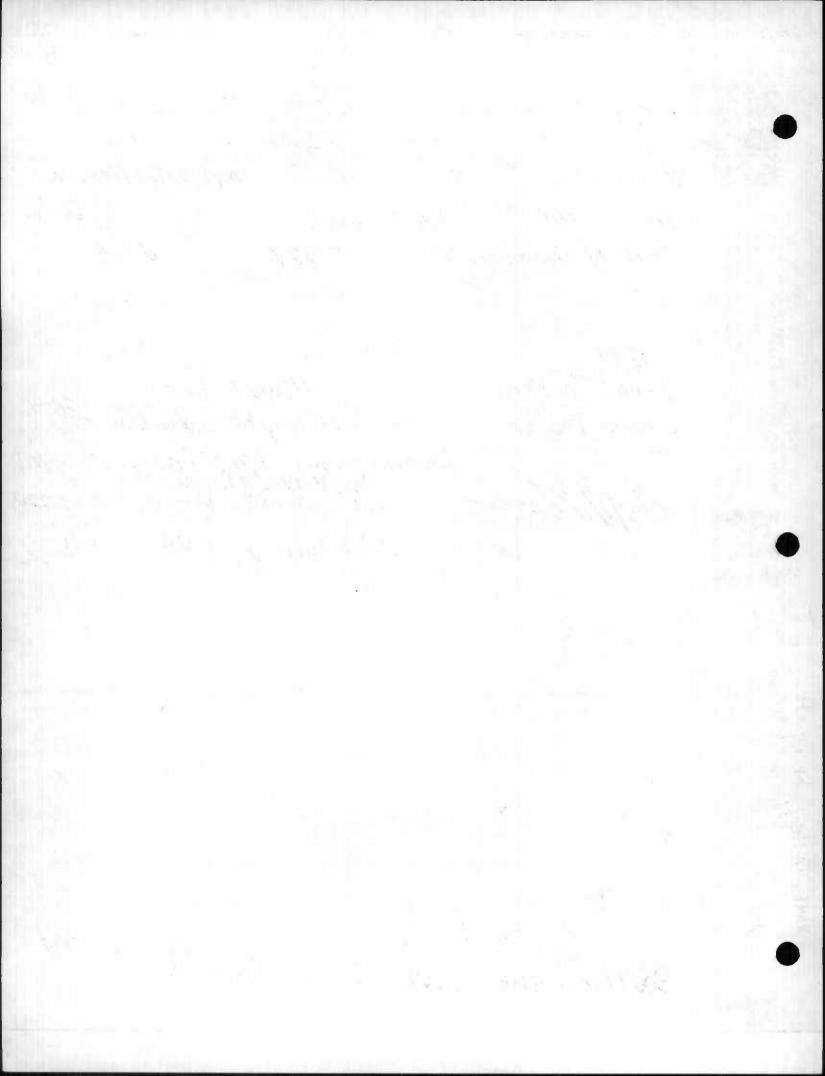
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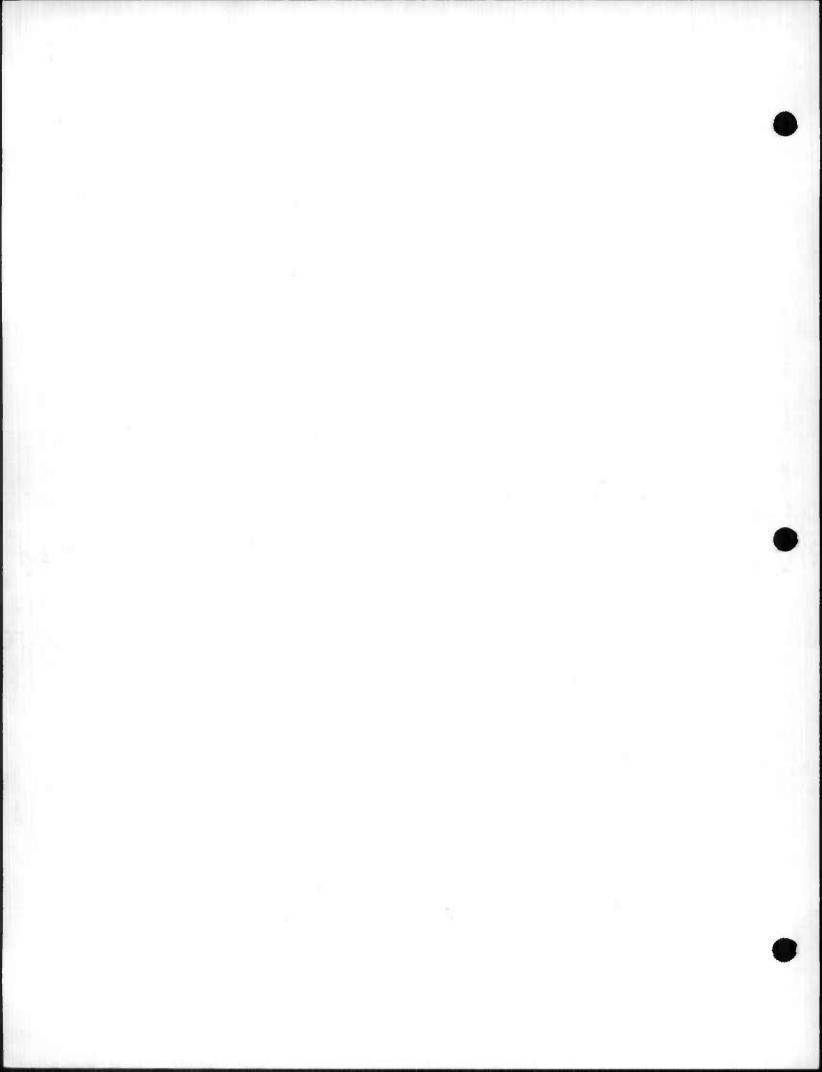
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and 21215-0020 be filed within 72 hours effer death with the Meryland tall Hygiene. d other than "natural", or items 23e or 28e-f show svent, the Medical Examilier must be notified at	b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:		Specify:	BLACI	X
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or Health		20a. Method of Disposition 20b. Place of Disposition (Name of Commetery, crematory or other place)	Pate 2	Oc. Location - C	city or Town, St	ete
		1 Daurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	26/97/	hunna	5 Mi	1/5 MM
Baltimo permit. Pag Depertment Important: I any Injury o		21. Signature of uneral Service Licensee 22. Napril and Address of Facility 72	HTIMER	NI Bhn	ns Ti	P
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Ital	Be	25. Was cese referred to medical examiner?	(Check only one)		
of Vital Re Physician: The ia r this certificate has	To	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 ☐ Nursing Hor	me 5 Resider	ice 6 DOther	(Specify)	
On o on o ding Ph	on:	1 Netural 5 Pending (Month, Dey Year) injury Work?	28d. Describe how	v Injury occurre	d	
Division or Attending I after death. Director: After	Certification:	2 Accident Investigation M 1 Yes 2 No				
Division of the state of the st	E	3 ☐ Suicide 4 ☐ Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	et and Number State)	r or Rural Rout	a Number,
** = = 0		200 Contilled No. 4M - Day Island				
o the Hospita ithin 24 hours of the Funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, a complete of the course one) 2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred one)	and due to the cer ed at the time, de	use(s) and man te and plece, ar	ner as stated. nd due to the co	euse(s)
To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certified 29c. License number	_ 29	d. Date signed	(Month, Dev. Y	'ear)
F 3 F 8		1. (Werberch 1/1695		Mer.		
0,		30. Name and address of person who completed ceuse of death (Item 23a) Type, Print)		1	~~,'	//
10		SOO CATONAVENUE 21229 Andrew A	verbac	h		
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tal or attending physician.	for use as the burial-tran		
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IONG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages	or removal.	marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ate be executed within 24 h	ysician and completely filled	death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	traumatic event, the r
ires that the death certifica	signed by the attending phy	Health and Mental Hygiene	ws any injury, or other
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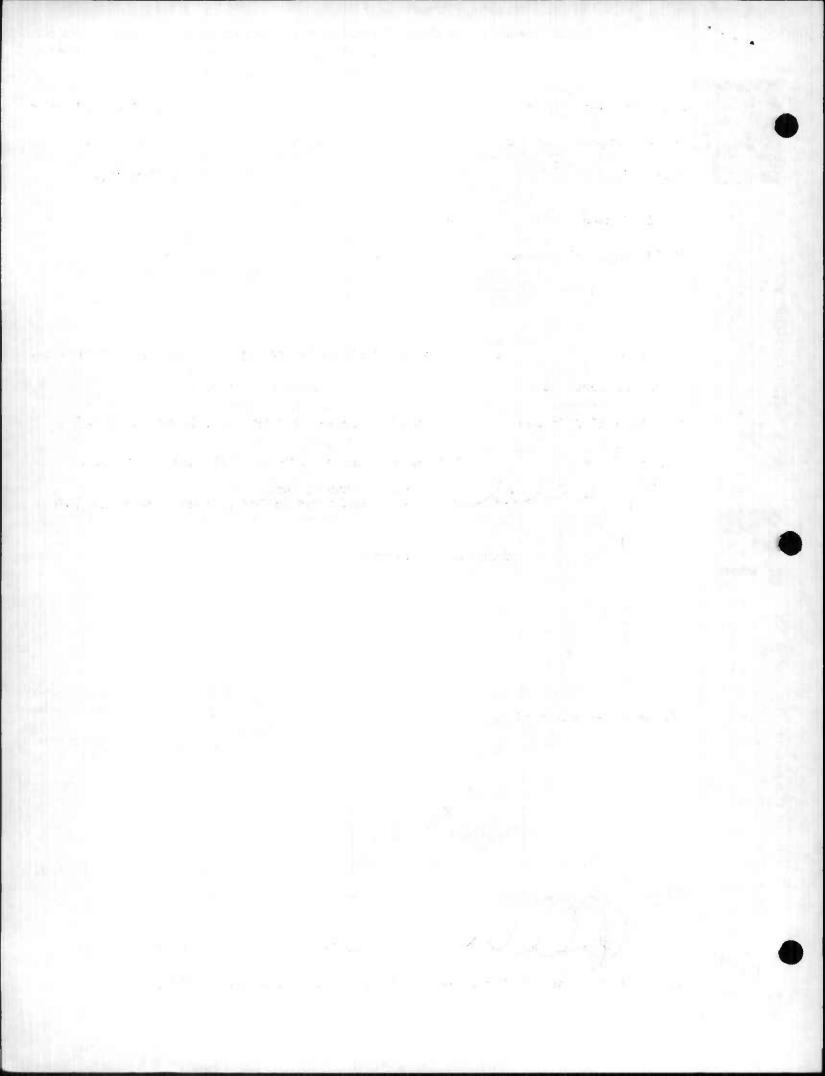
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3 Sulcide 4 Nomicide 5 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE/OF/CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WRO COMPLETED CAUSE OF DEATH (TEM 27) (Type, Prid) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE) 33. DATE FILED (Month, Day, Year) 34. REGISTRAR'S SIGNATURE)	YP	to a set of set of	(Month, Day, roa)	,,,,,					
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State of Maryland / Department of Health and Mental Hygien 3 5 9 0 8

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edical miner	4.	Fecility Name (If not institution, give				- 1	4b. City, Town, or				10:00 an
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ral		Social Security Number 6. S		e (In yrs. lest birthda	gy) If Under	1 Year		8. Date of Bir			
lor		253-56-5108	MAL OF	50 Yrs.	Months	Days	Hours Min	8. Date of Bit (Month, De Dec. 10	by, Year) 5, 1936	Georg	ce (Stete or Foreign La
		a. State 10b. County		10c. City, Town or	Location					100	I. Inside City Limits
ō	N	Maryland Howard		Laurel							1 ☐ Yes 2 No
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ompleted by Funeral Director	1	0373 Scaggsville	Road		2072				USA	mai oodiini	
by Funeral Director	•	Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 🖾 Yes 2 🔲 N If Yes, Give Yeer or Detes:	Ever In U,S. 1	3. Was Deced ff Yes, spec		Hispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		e - American ck, White, etc	o
Completed		15. Decedent's Ed	ucation	16a. De	cedent's Usua	Occup	pation	dilan	16b. Kind of 8		
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5		12	2		e Presi	iden	nt/Secret	ary	Microfi	.1m sei	cvice Co.
Be (Fether's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden Sumen	10)	
2		leveland Jones W	a11				Jane Ly	le Porte	er		
		a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	ailing Address	(Street	and Number or R	ural Route Numb	er, City or Town,	Stete, Zip C	ode)
	J	ane G. Wall / Sp	ouse	103	73 Scag	ggsv	ville Roa	d, Laure	el, Mary	land 2	20723
	20	a. Method of Disposition		20b. Place of Dis	sposition (Nameremetery or or	ne of ther ple	ce)	Date	20c. Location -	City or Town	n, Stete
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Domation 5 ☐ Other (Specify					ton Crem	. 11/24	Laurel.	Mary1	land
ė	21	Signature of Funeral Service Licen	990	202021110	22. Name and			11/27	Dadiet,	1141 9 1	Larra
once.		11. TC	717				ral Home Spring I				
er		sulting in death)		rdial Inf							
ledical Examiner	Se if 6	quentially list conditions, my, leading to immediate use. Enter Underlying use (Disease or injury It initiated events	b	Due to (or as a cons	sequence of):						
Medical	Ca the res	use (Disease or injury at initiated events sulting in death) Last	C	Due to (or as e cons	equence of):						
Physician/N		S	d								
ysic	Per	t II. Other significant conditions co	ntributing to death bu	t not resulting in the	underlying ca	ause giv	en In Part I.	23b. Did	tobacco uss co	ntribute to th	ne cause of death?
	_	Colon - vesicula	r fistula					130	Yss 2□ No	3 Probai	bly 4 🗆 Unknow
									en eutopsy ermed?	avalla	eutopsy findings able prior to eletion of cause ath?
pieted by								10	Yes 2 No	101	res 2∏ No
Completed	25.	Was case referred to medical					26. Place of De	ath (Check only o	one)		
Be Completed	25.	examiner?	Hospitel:	nt 2 X ER/Outpat	lent 3□ DO	A Oth	nor:			er (Specify)	
To Be Completed	27.	examiner?	Hospitel: 1 ☐ Inpatier 28a. Date of Injun (Month, Dey	28b. Time		Bc. Injur Wor	ner: 4 D Nursing F	lome 5 Real			
Be Completed	27.	examiner? 1 Yes 2 No Menner of Death 1 Natural 5 Pending	28a. Date of Injun (Month, Dey	Year) 28b. Time Injury	of 25	Bc. Injur Wor	ner: 4□ Nursing F y et rk?	lome 5 Real	dence 8 Doth	red	Route Number,
Certification: To Be Completed	27.	examiner? 1 Yes 2 No Menner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined a. Certifier	28a. Date of Injun (Month, Dey	Year) 28b. Time Injury ry - At home, farm, (Specify) i my knowledge, de examination and/or	of M 25 M street, factory.	Bc. Injur Wor 1 D	ner: 4 □ Nursing H y et kr? Yes 2 □ No	28d. Describe 28f. Location (City or Tox	dence 8 Oth how injury occurr Street end Numb wn, State)	er or Rurel R	ad .
To Be Completed	27.	examiner? Yes 2 No	28a. Date of Injun (Month, Dey 28e. Place of Injun building, etc. rafcium: To the best of liner: On the basis of	Year) 28b. Time Injury ry - At home, farm, (Specify) i my knowledge, de examination and/or	of M Street, factory, ath occurred a Investigation,	Bc. Injur Wor 1 , office	ner: 4 □ Nursing H y et kr? Yes 2 □ No	28d. Describe 28f. Location (City or To) , and due to the rred at the time,	dence 8 Oth how injury occurr Street end Numb wn, State)	er or Rurel R	ed. e cause(s)
edical Certification: To Be Completed	27.	examiner? Yes 2 No	28a. Date of Injun (Month, Dey 28e. Place of Injun building, etc. rafcium: To the best of liner: On the basis of	Year) 28b. Time Injury ry - At home, farm, (Specify) i my knowledge, de examination and/or	of M 24 M 24 M M 24 M M M M M M M M M M M	Bc. Injury Wor 1 office t the tir in my o	ner: 4 Nursing H y et rk? Yes 2 No me, dete and place pinion, death occur se number	28d. Describe 28f. Location (City or To) , and due to the rred at the time,	dence 8 Oth how Injury occurs Street end Numb wn, State) cause(s) and me date and place, 29d. Date signed	ner or Rurel R nnner es state and due to the	ed. e cause(s) y, Year)
edical Certification: To Be Completed	27.	examiner? Yes 2 No	28a. Date of Injun (Month, Dey 28e. Place of Injun building, etc. accian: To the best of iner: On the basis of and manner stat	Year) 28b. Time Injury - At home, farm, (Specify) imy knowledge, de examination and/or ed.	of M 2th M 2	Bc. Injur Wor 1 , office	ner: 4 Nursing H y et rk? Yes 2 No me, dete and place pinion, death occur se number	28d. Describe 28f. Location (City or To) , and due to the rred at the time,	dence 8 Oth how Injury occurs Street end Numb vn, State) cause(s) and medate and place,	ner or Rurel R nnner es state and due to the	ed. e cause(s) y, Year)



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JEFF WILSON November 23 EDDIE /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore maryland NIA If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In ym! last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Montha Davs 1X M 20 F 213-34-1062 SEPT, 15, 19/3 SOUTH CAROLINA Yrs Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2□No Director MARYLAND 10e. Street and Number Og. Citizen of What Country? 3414 SPELMAN ROAD 21225 USAI Funeral 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo if Yes, Give 1 Yes 2 No by If Yes, Give Year or Dates: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) UNKNOWN JANITOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILSON REBECCA 2 EDDIE CMN-UNKNOWN 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3414 SPELMAN ROAD BALTIMORE, MD. 21225

(as of Disposition Name of Part | Date | 20c. Location - City or Town, State RUTH PORTER WILSON (WIFE, 20a. Method of Disposition

10 Buriai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Piaca of Disposition (Name of cemetery, crematory or other place) CEMETERY 11-28-97 ARBUTUS, MARYLAND 21. Signature of Funeral Servica Licensee BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVENUE. Sharron Sykins BALTIHORE, MD. 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause off each line, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Denknown 24b. Were autopsy findinga available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homiclde 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

The lew requires that the death certificate be execu 68760, Box Division of Vital Records, P.O. or Attending Physician: n 24 hours after death.

Ne Funeral Director: Af pletely filled in by the fu death. the Hospital within 2 To the

Examiner

Funeral

Director

the Meryland

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Merylar Department of Health and Mental Hygiene.
Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examiner must be neutrical anone.

Physician /Medical

Examiner

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Examiner

Physician/Medical

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Certification: To

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29b. Signature and title of certifier

CH //WE
31. Date filed (Month, Day, Year)

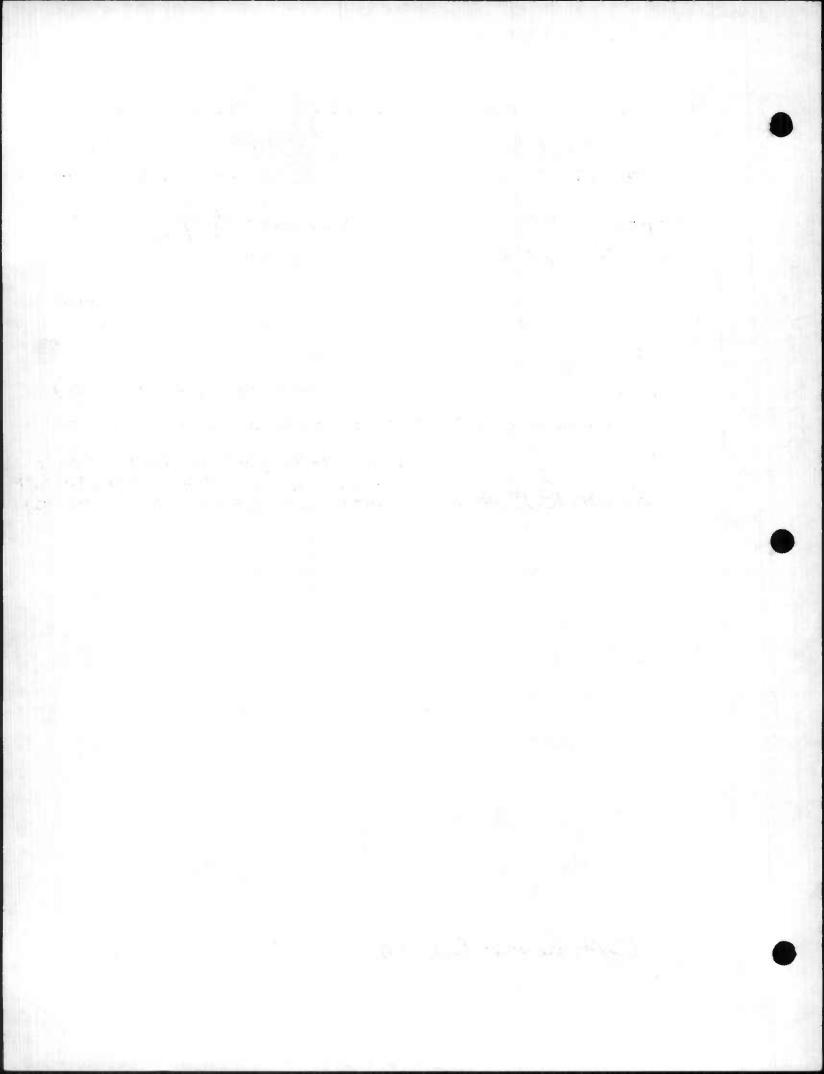
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

NOV 26 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Death Month **Physician** ugene 4b City, Town, or Location of Deeth /Medical 4e. Facility Nania (If not institution, give street and number 4c. County of Death **Examiner** (gev. Ulf Undar 1 Year Months Days Hours Min. (M rundal 5. Sociei Sacurity Number 6. Sax 7. Aga (In yrs. lest birthday) Birthpleca (Stata or Foraign Country) **Funeral** M 20 F 218-28-5442 65 Yrs. Director Maryland Usuel Rasidance of Dacedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 7 is marked other than "naturel", or itema 23e or 28a-f shor traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Queen Anne Stevensville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 420 Butlers Landing 21666 USA death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes Δ M No if Yas, Giva Yeer or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or ther any injury or other traumatic event, the Medical Examina-1 Navar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorcad White Completed 16a. Dacedant's Usuai Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadant's Education (Specify only highast greda complated) 16b. Kind of Business/Industry Gasoline Collega (1-4or 5+) Elementery/Secondary (0-12) Owner/Operator Station 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Surname) Frank Wesolowski Sophia Zisk 19a. fnformant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 420 Butlers Landing Stevensville, MD21666
ca of Disposition (Nama of Data 20c. Location - City or Town, State Joyce B. Wesolowski/wife 20a. Method of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Ramoval from Steta Metro Crematory, Inc. 11/25/97 4 Donatiop 5 Other (Specify) Baltimore, MD 21. Signature of Funefal Service Lice Cremation Society of Maryland, Inc. Edward A. 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate intervel Batween Onset end Death **Physician** /Medical immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner rteriosa sician and burial-transit Sequentially list conditions, if eny, laading to Immediata cause. Enter Undarlying Ceusa (Disease or Injury that initiated avants rasulting in death) Last attending physician for use es the buria P.O. Box 68760 Physician/Medical Dua to (or es e consequance of): signed by the aid to be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 CUnknown 1 ☐ Yes 2 ☐ No CINOMA Records, should b 24b. Wara autopsy findings evallebla prior to complation of causa of deeth? Completed 24e. Was an autopsy performed? 2 2 No certificate 1 🗆 Yas 1 ☐ Yes 2 ☐ No Division of Vital To the Hosertat or Attending Physician: within 24 hours ager death.

To the Funeral Director: After this certifical completely filled In by the funeral director; I 25. Was casa raferred to medical 26. Pleca of Death (Check only ona) axaminer? 1 ∠ ves 2 □ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ inpatient 2 ☐ FN/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) Certification: 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and placa, and dua to the ceusa(s) and menner es stated.

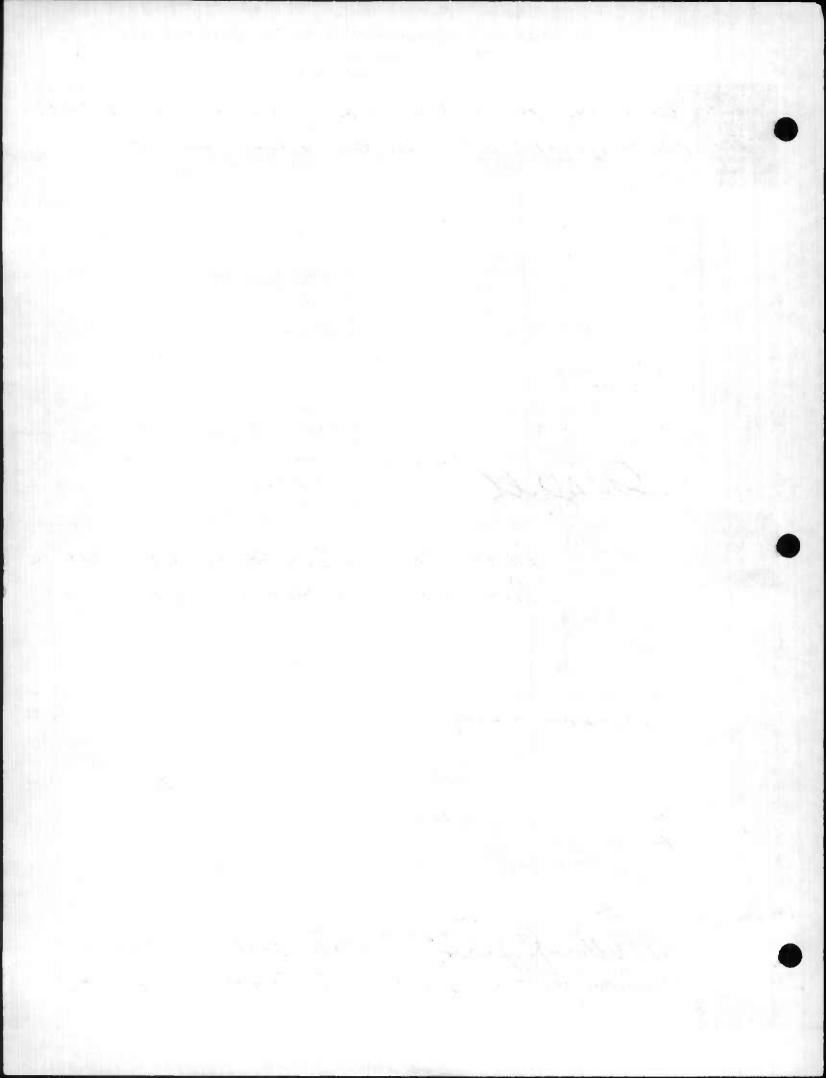
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the tima, deta end placa, and dua to the causa(s) and mannar stated. 29a. Certiflar Medical 29b. Signeture end fitta of certifier 29c. License number 29d. Dete signed (Month, Day, Year) eputy 06054 30. Nama and address of parson who completed cause of death (Itam 23a) (Type, Print) 11/1, Am ones, mo

State Registrar 92 Registrar's Signatura

July Navy (Non-Handell

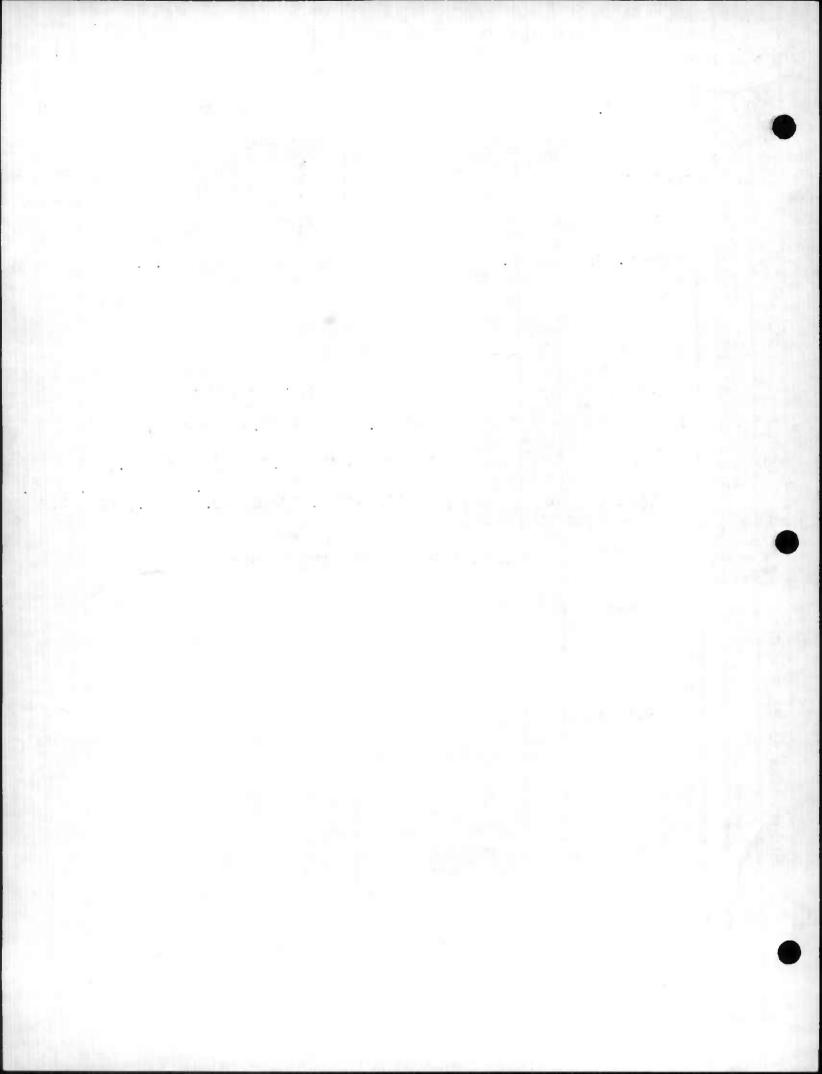
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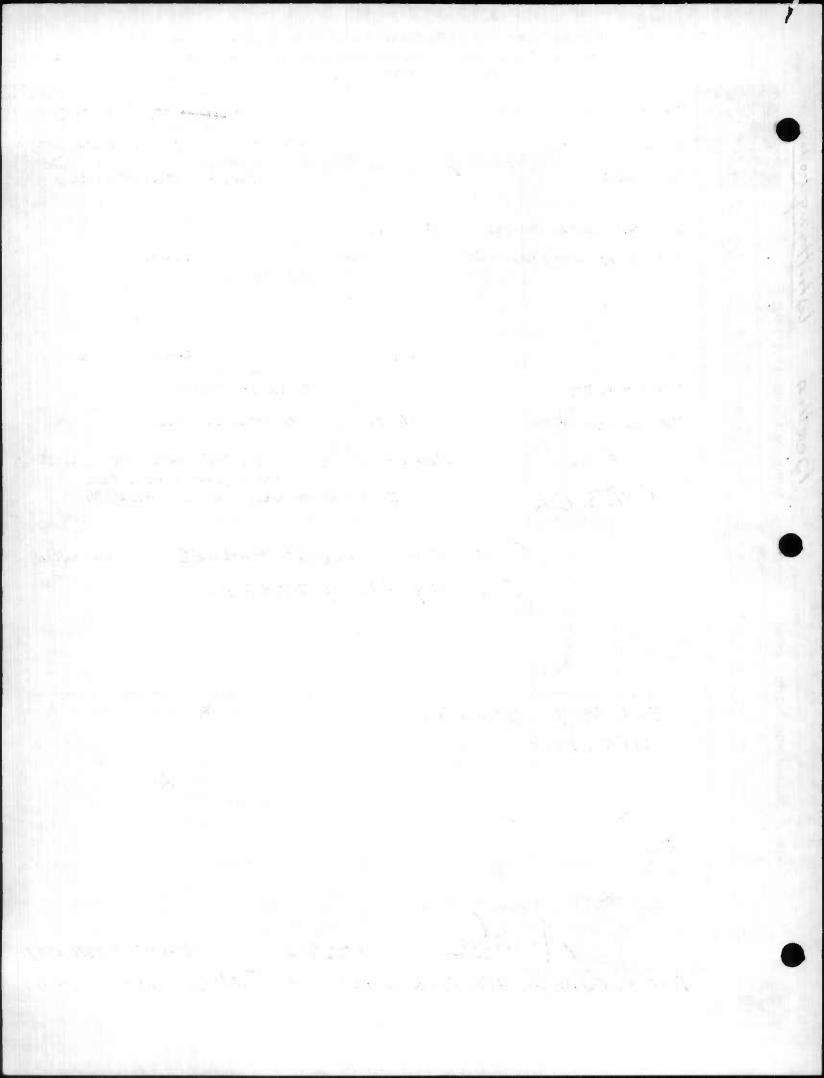
LYN H. V	A ETEX				Ce	rtificate o		1	Reg. No.		
Physi	cian	Decedent's Nama (First, Middla, L						2. Date of Dea	ath Dey	Year	3. Tima of Death
/Med		EVELYN H. WEED	4S					NOVEMBE	ER 13,	1.997	0641AM
Exam	iner	4a. Facility Name (If not institution, gi	iva street and number)				4b. City, Town, or L	ocation of Death	4c. County	of Death	
	Ι,	1024 NORTH GILMO	RE STREET				BALTIMOR	E CITY		N/A	
Funera Directo		215-16-9104	Sax 7. Ag 1 □ M 2 X F	76	ast birthday, Yrs.	Months Day		8. Date of Birt (Month, Day 8 / 29 /		9. Birthola	ace (State or Foreign D) LAND
pul *		Usual Residence of Decedeni 10a. Stata 10b. County		10c City	Town or L	ocation				100	d land of Old I land
e Maryla	Director	MD N/A		Toc. City,	, TOWITOI L		IMORE			100	d. inside City Limits 1X Yes 2 No
# th	- E	10e. Streel and Number				10f. Zip Code			10g. Citizen of	Whal Country	y?
h wi		1024 N. GILMOR	RE ST			21	217		II C		
dea fue	Funeral	11. Maritai Status	12. Was Decedent	Ever in U,S	3. 13.		Hispanic Orlgin? (Sp ban, Mexicen, Puarto	ecity Yes or No-	14. Rac	ce - Americer	n Indian,
filled within 72 hours after death with the Maryland Hygiene. The first star 1884 above ont, the Medical Evantual to notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Yes Give Year or Dates:	No		1 ☐ Yes 2 ☐ N		Rican, etc.)	Specify Specify	CK, WHITE, OF	IC.
d within 72 hours af giene or than "natural", or tre Modrel Exam.	Completed	15. Decedent's E	ducetion	T	16a. Dece	dent's Usuai Occ	upation		16b. Kind of B		
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should be nd Mental marked o	ToB	ROBERT FIELD	2				UENDIET	TIA DOM	'ED		
should by and Menta	-	19a. informant's Name/Relationship	-2		19b. Maili	ing Address (Stre	HENRIET et and Number or Rur			State Zin C	Code)
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00		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)								Ony or row	ii, Stata
tmer tant		4 Donation 5 Other (Speci	**	BAL'	TIMO	RE NAT	L CEM. 11	/18/97	BALT	0., 1	MD
permit. Peg Department Important: I any Injury o		21. Signature of Funeral Service Lice	nsaa //		2.	2. Name and Add	ress of Facility	NON P	BATTE	ווים עי	N. SERV
20583	SI .	Vernon Du	W MO	0014	1.	721-27	N. MONRO	F ST _	BAITO	MD TE	N. SERV.
		23a. Part1. Enter the diseasa, or con shock, or heart failure. List only	nplications that causage	tha death.	Do not en	ter the mode of d	ying, such as cerdiac	or respiratory ar	rest,		Approximate
Physician		snock, or near failure: List only	one cause on each II	ne.							interval Between Onset and Deeth
/Medica	_	Immediate Cause (Final									
Examine	_	disease or condition resulting in death)	a. Arterio	scler	otic	Cardiova	scular Dis	sease			
	a			Due to (or	as a conse	quence of):					
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icate be executed physician and s the burial-transit	xan	Sequantially list conditions,		Dua to (or	es a conse	quence of):					
ficate be ex physician as the burial		Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury									
nysic he b	2	that initiated events resulting in daath) Last	C	Due to (or a	as a consec	quance of):					
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eath cer attendin			d								
death cer e attendin d for use	Physiclan/	Part II. Other significant conditions	contributing to death b	ut not result	ting In the u	indarfuina cause a	thren in Part i	23h Didt	obacco usa co	ntribute to t	the cause of death?
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lclan: The certificate rector, pag	Be	25. Was cese referred to medical					26. Place of Deat	h (Check only o	ne)		
	To	examiner? 1萬Yes 2□ No	Hospital:	ent 2 E	R/Outpatie	nt 3 DOA	Whor	me 5 Resid		ner (Specify)	
		27. Manner of Death	28a. Date of Inju (Month, De		28b. Time o			28d. Describe h			
ding it. th. After funer	2	1 ⊠Naturai 5 ☐ Pending 2 ☐ Accident Investigation		y Yeer)	Injury		ork? ☐ Yes 2 ☐ No				
Attending or death.	Ca	3 Suicide 6 Could not b		uny - At hom	ne farm st	reat factory office	9	28f. Location (S	Street and Numb	ber or Rural F	Routa Number
l or Attending after death. Director: Afte d in by the fune	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	10, 14111, 00	raat, factory, office		City or Tow			,
2 5 2		00.0.00									
To the Hospital or vithin 24 hours after 16 the Funeral Director of the Funera	edical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the lime, date and place, and due to the ceuse(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.									
0 00	1	29b. Signature and litle of certifiar	4			29c. Licer	nse number		29d. Date signe	ed (Month, De	ay, Year)
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		wys 1	V Va	· · ·	/ M	P	O.C.M.E.		NOVEMBE	ER 13,	1997
		30. Name and address of person who		eath (Item)		·					
		Stephen Radentz,		1.0		Penn Str	eet, Balt	more, M	laryland	1 2120	1
	tate	31. Date filed (Month, Dey, Year)	32. Registra	ars Signatu	9-00						
Regis	trar	NOV 2 6 1997	Transie mile	Mon-Na	MURRICA						



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State of Maryland / Department of Health and Mental Hygiene 7 359 12

	_				,	Certifica			i weman n	Reg. No.		,,,,		
Physic /Medi Exami		ian	Decedent's Neme (First, Middle, L.						2. Deta of De Month	eeth Dev	Year	3. Time of Deeth		
			Bertha Gertrude	Whittingt	on				Novem	ber 17,	1997	2:45pm		
		ner	4e. Facility Neme (If not institution, g					4b. City, Town, Candov	or Location of Deal		y of Deeth			
		-	Doctor's Hospita 5. Societ Security Number 6.		In yrs. lest bi	athday) If Unde	er 1 Year			Prince Geo				
	Funeral Director		578–24–2933 Usuel Residence of Decedent	4.1	86	Yrs. Months			in. (Month, D	9, 1911		otece (State or Foreign otry) ginia		
	yland		10a. Stete 10b. County	1	0c. City, Tow	m or Location					1	Od. Inside City Limits		
	a Mar	ctor	Maryland Prince	e Georges	Colle	ge Park						1 Yes 2 □ No		
	or 28	Dire	10e. Street and Number			10f. Z	p Code			10g. Citizen of		ntry?		
Maryland 21215-0020 2 should be filed within 72 hours after death with the Marylend	s 23e	ie i	4711 Berwyn Hous	-			740			U.S.A.				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumente event, the Medical Exporter is suit be notified at sonce.	by Funeral Director	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Morroed	12. Wes Decedent Ever Armed Forces? 1 Tyes 2 No If Yes, Give Year or Detes:	er in U,S.	13. Wes Dece tf Yas, spe		dispanic Origin? an, Mexicen, Pu Specify:	(Specify Yes or Ne erto Ricen, etc.)	o- 14. Re Ble Specii	ce - Americ ock, White, White, fy:	etc.		
5-0	72 ho	eted	15. Decedent's 8 (Spacify only highest g	ducetton rede completed)	16e	. Decedent's Use	uel Occup	pation during most of v	vorkina	16b. Kind of E	Business/In	dustry		
121	na. han	Completed	Elementery/Secondery (0-12)	-	(Give kind of work done during most of work life. DO NOT use retired)				Department S					
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and	od be	Be C	William H. Day	.,					h Ann Cai		me)			
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Baltimore,	Pagas 1 a sent of Hax nt: If item ry or othe		20e. Method of Disposition 1 Burial 2 Premetion 3 4 Donetlon 5 Other (Spec	Ramovat from Stete	cemete	of Disposition (Ne ry, cremetory or SON Crem	other pla		Date 11/20/97	20c. Location 7 Locust		own, State		
Balti	Departm Departm Importa any Inju		21. Signature of Funeral Service Lice	**					oser Fund					
-	_		233 Broadview Ave., Warrenton, VA 20186											
	Physician		23a. Part1. Enter the disease, or complications that ceused the death. Do not antar the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate there is a cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Onset and Death											
	/Medical		Immediate Cause (Final disease or condition ONGESTIVE CARDIAC FAILURE ONE WELL											
	Examiner		resulting in death) Due to (or es e consequence of):											
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	and I-tran	хаш	Sequentially list conditions, If any leading to immediate											
68/60,	tificeta be executed g physician and as the buriel-transit	edical Examiner	Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Disease or thijury that initiated events	c										
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50	Afta funa	tlon	28e. Dete of trijury 28b. Time of Injury 28c. Injury at Work? 1 Accident Investigation 28c. Dete of trijury 28b. Time of Injury M I Yes 2 No											
pital or Attending	To the Hospital or Attending Phy within 24 hours attendanth. To the Funeral Director: Aftar this complately filled in by the funeral	Certification:	3 Sulcide 4 Homicide Could not be determined 28e. Plece of trijury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Ro City or Town, Stete)								al Routa Number,			
	pours derail		29a, Certifier 12 Certifying P	valcian: To the best of a	v knowlada	death accurren	at the ti-	me dete and sta	ne and due to the	causals) and -	9000100	teted		
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	withir To th	Me	11/2/4/4							29d. Date signe	ned (Month, Day, Year)			
			30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ASLFS. QADRI, 4700 REFLWYN HOUSE RD, C							November 1871,19				
			30. Name and address of person who	completed ceuse of deet	h (Item 23e)	(Type, Print)	ous	E RD,	Collec	SE PA	RKI	nD 2140		
	Sta	ite	31. Dete filed (Month, Day, Year)	32. Registrer's	Signeture					_				
	Registr	rar	NOV 26 19	9/ Julia D	avidson	Randell								



7-6788-04 CHRISTON YOUNG Physi	PHE	R 1. Decedent's Nama (First, Middle, Las CHRISTOPHER DWA	State of Marylan State of Marylan State of Marylan State of Marylan State of Marylan State of Marylan	Black Indelible In and / Department of Certificate o	Health and M f Death	Mental Hygier Reg. 2. Date of Death Month NOVEMBER	ne ₉₇	35913 3. Time of Death
Funera Directo	1	4a. Facility Name (If not institution, give MURPHY ST. AND JC 5. Social Security Number 6. Sr 267-71-1394	HNATHAN STREE			4c. County of De VASHINGI 9. E 2 FL	eath	
death with the Maryland ms 23a or 28a-f show Linuit be notified at	Director	Usual Residence of Decedent 10a. State 10b. County FL ST LUC 10e. Street and Number	10c. Ci	ORT PIERCE 10f. Zip Code	3		Citizen of What	10d. inside City Limits
after or No	by Funeral D	1003 S. 27th ST 11. Maritel Status 12 Never Married 2 Married 3 Widowed 4 Divorcad	PREET 12. Was Decadent Ever in Under Forces? 1 Yes 2X No If Yes, Give Year or Dates:	34947 J.S. 13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Sp uban, Mexican, Puerto lo <i>Specity:</i>	pecity Yes or No- Rican, etc.)	merican Indian, hite, etc. BLACK	
and 21215-0020 be filed within 72 hours af tal Hygiene. d other than "natural", or event, It a Micolcal Eram	Completed	15. Decadent's Ed (Specify only highest grad Elementery/Secondery (0-12) 9	16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	ne during most of work ired) ED	ting 16b.	16b. Kind of Business/Industry N/A		
ore, Marylan ss 1 and 2 should b of Health and Ment teem 27 Is marked other traumatic e	To Be	ALBERT BENJAMIN 19a. Informant's Name/Relationship (7 LORETTA YOUNG (20a. Method of Disposition 1 \$\infty\$Burial 2 \$\infty\$Cremation 3 \$\infty\$ 4 \$\infty\$Donation 5 \$\infty\$Other (Specify)	ty or Town, State CE, FL Location - City	34947 or Town, State				
Baltimo Baltimo Bernit. Page Whedica Important: if Baltimo Bal		21. Signature of Funeral Servica Licentification 23a. Part 1. Enter the disease, or compshock, or heart failure. List only of the disease or condition	see Vecto CFSP Dications that caused the dea	22. Name end Add BALTIMOR th. Do not enter the mode of d	EL. E, MD. 2	IZABETH 1 1217-172 or respiretory errest,	L. PHI	
68760, fricate be executed a physicien and as the burial-transit	edicai Examiner	resulting in death) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or es a consequence of): or es a consequence of): or as a consequenca of):				
P.O. B.	y Physician/M	Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlying cause	given in Part I.	400	ute to the cause of death?	
Il Records, The law requires to sate has been signe page 2 should be to	Completed by				24a. Was an eu performed		b. Were eutopay findings available prior to completion of cause of death? Yes 2 No	
of Vital Physician: This certification and director, po	To Be	25. Was case referred to medical exeminer? 1 X Yes 2 □ No 27. Manner of Death		ENOUIDATION 30 DOA	Other: 4 Nursing Ho	th (Check only one) ome 5 Residence	6 ▼JOther (S	
Olivision or Attending latter death. Director: After in by the fune	ertification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	u on i	ome, ferm, street, factory, office	Yes 20 No	28d. Describe how in 28f. Location (Street City or Town, St	and Number or	Rural Route Number,

Phys Completed by Medical Certification: To Be To the Hospital or Attendiviting 24 hours after death To the Funeral Director. /

31. Dete filed (Month, Dey, Year) NOV 2 6 1997

29b. Signato

Tomicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

O.C.M.E.

NOVEMBER 24,1997

(Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

who completed cause of death (Item 23a) (Type
32. Registrar's Signeture
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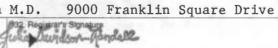
	Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3.1										3. Tima d	of Death		
Physician /Medical	Catherine M. ZEALOR								Month	ber 22	, 1997	7:25		
Examiner	4a Facility Nama (If not institution		4b. City, Town, or t											
neral	Franklin Squa 5. Social Security Number	re Hospit		Center Roseda Aga (In yrs. last birthday) If Undar 1 Year If Undar 24 Hr.				24 Hrs.			1timor 9. Birth		or Foreign	
ctor	218-18-8405 Usual Rasidance of Decedant	74	Y	s. Months	y) If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. June 10, 19				0,1923	9. Birthplaca (Stata or Foreig Country) 1923 Maryland				
70	10a. Stata 10b. County Maryland Balt		Town or Location Baltimore County						10d. Inside City Limits 1 ☐ Yas 2☐ No					
once. To Be Completed by Funeral Director	10e. Street and Number						10g. Citizar	10g. Citizan of What Country?						
a O	5140 Terrace D	21236					USA							
by Funeral Director	1t. Marital Status 1 □ Nevar Married 2 □ Man 3 ◯ Widowed 4 □ Divorced	If Yas Give			S. 13. Was Decedant of Hispanic Origin? (S If Yas, specify Cuban, Maxicen, Puart					Specify Yas or No- rto Ricen, atc.) 14. Race Blac Specify			e - Americen Indian, ck, White, etc.	
ted	15. Decedent's Education (Specify only highest grade completed)			16a. C	16a. Decedent's Usual Occupation					16b. Kind of Bus				
Completed	Elemantary/Secondary (0-12) Collega (1-4or 5+) 11th grade N/A				(Giva kind of work dona during most of working iffa. DO NOT usa ratired) Machine Operator Martin Mar							etta		
To Be	Theodore Maggi	17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Angelina Cicero												
-	19e. Informent's Neme/Raletions	hip (Type, Print)			Meiling Addrass			er or Aur	al Routa Num	ber, City or T	own, Stata, Z	ip Coda)		
	Mrs. Linda M.	Chandelle Rd. Baltimore, Md. 21220 isposition (Nama of Data 200. Location - City or Town, State						Town State						
	X Burial 2 ☐ Cramation	cemate				tary, cramatory or other place) ens of Faith Cem. 11-26-97 Baltimor								
	21. Signatura of Funarai Service		1		22. Nama and				200					
ă	Longle (dass	colu		Lassa 7401	Bela	ir Ro	1. B	altimo	re, Md	2123	6		
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l r	Immediate Cause (Final disaasa or condition rasulting in daath)	nfarction a consequence of):						-	15 Mi	nute				
iner		insaquance on).	mice oi).						12 Ho	ours				
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Physician/Medic	rasulting in death) Last Dua to (or as a consequence of):													
sician	Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death.									of death				
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ompleted by										as an autopsy formed?	8	Vara autopsy vallable prior completion of daeth?	rto	
Com									1)	Yas 201	No 1	Yas 2[□ No	
Be	25. Was cese rafarrad to medice axaminar?	Hospital: 3	Inpatient 2			Oth	er _		h (Chack only					
on: To	1 ☐ Yas 2 No 27. Mannar of Death 1 ■ Naturel 5 ☐ Pandin	Tima of 28c. Injury at 28d. Descri					5 Rasidance 8 Other (Specify) Describe how injury occurred							
Certification:	2 Accident Invastigation				M 1 ☐ Yes 2 ☐ No me, farm, streat, factory, office 281. Lo. Cit.					81. Location (Straat and Number or Rural Routa Number, City or Town, Stata)				
Medical Certification: To Be Com														
		Physician: To the											(e)	
Medical Certi		kaminer: On the b	asis of examinet ner stated.		or investigetion,	in my o				e, date and pl		to the cause		

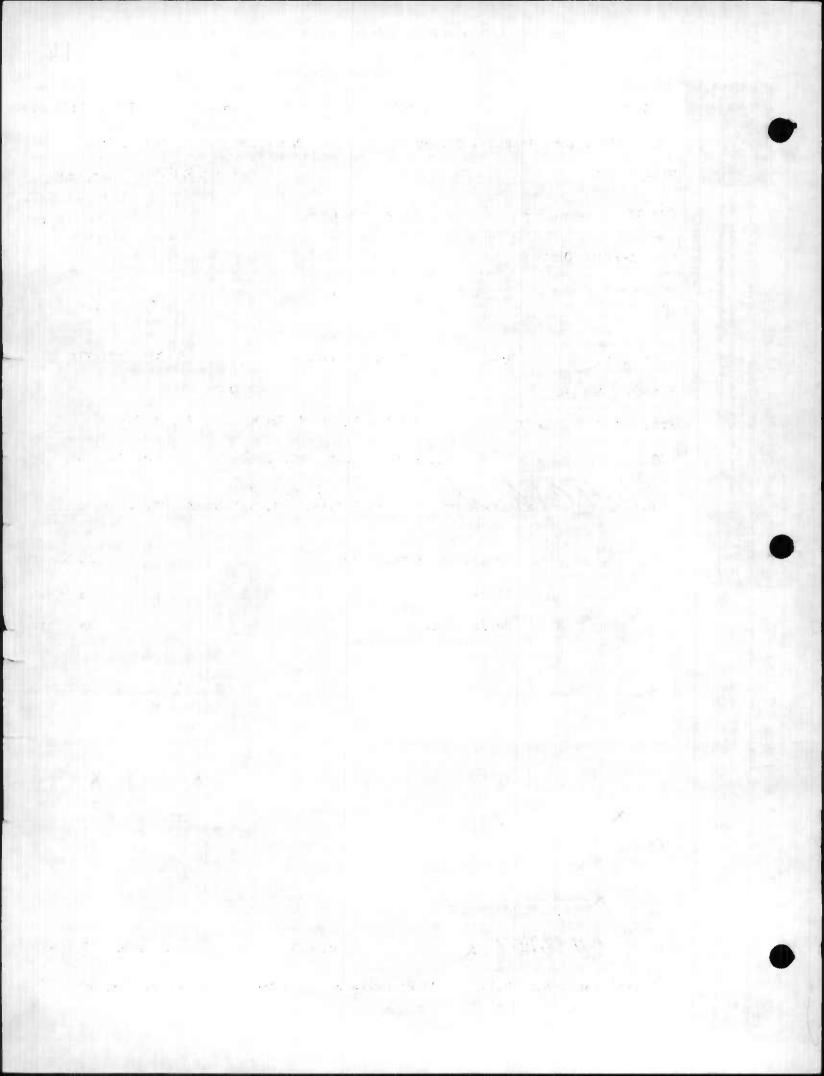
20

30. Neme end address of person who complated ceusa of daath (Itam 23a) (Type, Print) Rafael Perez-Mera M.D.

Baltimore, Maryland 21237

31. Data filled (Month, Day, Year) NOV 2 6 1997 State Registrar

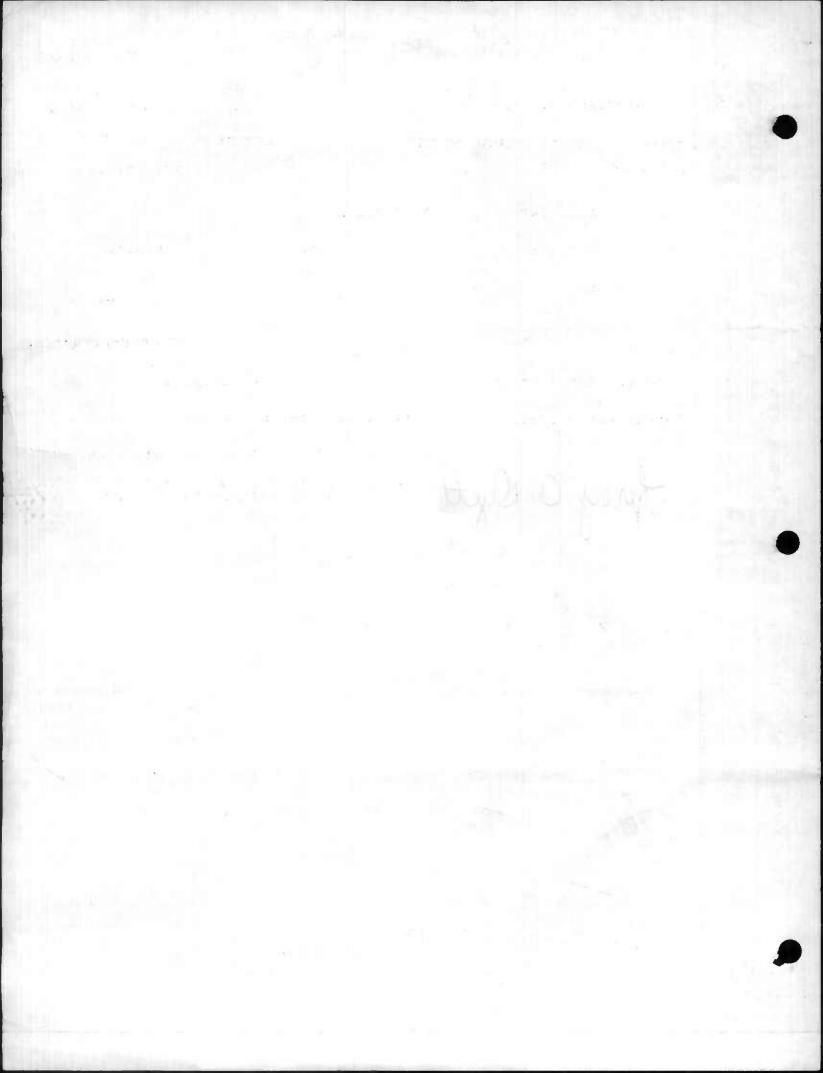




DHMH 16 Rav 6/95

O'DONALL ANDREWS

1						Cei	rtificate	of	Death			Reg. No.	, 0	
Physician		Decedent's Neme (First,									2. Dete of D Month	eeth Dev	Yaer	3. Tima of Death
/Medical	-	O'DONA	LD A	. ANDR	EWS						Noveml	०६६ वि		1412
Examiner	ľ	le. Fecility Neme (If not ins	stitution, giv	e street and num	ber)				4b. City, To	wn, or Lo	cation of Dee	th 4c. Co	ounty of Deeth	
	Ц	PENINSULA RI	EGIONA 6. S				If Under 1	Vane	and the second	the balance of	BURY		WICON	
eral ctor	1	219-76-564	1 1	M 2□F	Age (In yrs.)	Ym.		Days	Hours	Min.	8. Date of B	1°9′5 2	P. BIRT	nplace (State or Foreign Intry) IDAD
	-	Usuel Residence of Deced 10a. Stete 10b. 0			10c. City	y, Town or Lo	cation							10d. Inside City Limits
Director	2		LTIM	ORE			SVILL							1 ☐ Yes 2 🕅 No
8 0		614 RALST	ON A	VENUE			10f. Zip Co		208				of Whet Cou	
Examiner must	2	11. Maritel Status 1 ☐ Never Merried 2 3 ☐ Widowed 4 ☐ Div		12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or De	ces? Months		Wes Decedent Yes, specify				ecify Yes or N Rican, etc.)		Race - Amer Black, White pecify:	
pate		15. De	cadent's Ed	lucation de completed)		16e. Dece	dent's Usual C	Occup	pation	t of worki	na	16b. Kind of Business/Industry		
Completed		Elamantary/Sacondary (I		Collega (1-	4or 5+)		kind of work o DO NOT use 1 der	retire	d)	t of works	ng	McLe	an Co	ntracting
To Be C	3	7. Fether's Neme (First, N Maxmilli									(First, Middle a And		mame)	
		19e. Informent's Name/Rei				1.00	ng Address (S							ip Code) 0 21208
	1	20e. Method of Disposition 1 ☐ Burial 2 ☐ Crem	etion 3	Removel from S	tota C	ametery, crer	sition (Name matory or othe MOria.	r pla		72/2	Dete		tion - City or 1	Fown, Stete
by Physician/Medical Examiner		23a. Part. Enter the diametric and the condition resulting in death) Sequentially list condition resulting in death) Sequentially list conditions of eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury the finitieted evants resulting in death) Last	or comp	b. A c. Se d.	Due to (or Due to (or Due to (or	r as e consec	er the mode of the	IB of dyi	erry ock	HEI cardiec c	GHTS or raspiratory A1	AVE., arrest.	e contribute	OME, P.A. O. 21207 Approximeta Intarvel Batween Onset end Deeth
Completed by P											24e. Wa	s en eutopsy formed?	6	Vare autopsy findings eveileble prior to completion of cause
GILLO											,,	Yes 2		of death? □ Yas 2□ No
Be Com		25. Was casa referred to m	edical						28 Place	of Death	(Check only		40	□ Yas 2000
To Be		exeminar? 1 ☐ Yes 2 ☐ No		Hospitel:	Datient 2	ER/Outpetier	t 3□ DOA	Otl	hor				Other (Spec	eify)
neral		27. Mennar of Deeth) andina	28e. Deta of (Month		28b. Time of		fnju Wo			28d. Describe			**
the fur		2 ☐ Accidant i	Pending nvestigation		, Doy , car,	injury	М		Yes 2□	No				
led in by the funera Certification:		3 ☐ Suicide 6 ☐ 6 4 ☐ Homicide	Could not be datermined	28e. Plece of building	of Injury - At ho g, etc. (Specify	ome, farm, str	eet, fectory, o	ffice		1	28f. Location City or To	(Street end hown, Stete)	Number or Ru	rel Route Number,
completely filled in by Medical Certifi		29a. Certifier Ca (Check only 2 Me	rtifying Ph	yaiclan: To the b linar: On the bes end manna	ils of examinat	wledge, deeth ion end/or Inv	occurred et t vestigetion, In	tha ti	ma, dete en opinion, dee	d plece, e	end due to the	e ceuse(s) en	nd manner as ace, end due	steted. to the cause(s)
M		9b. Signeture and title of c	onething.	24.1	R.Ho	ela.			se numbar	0			igned (Month	
Y	-	O. Name end address of p.	arson who	complated cause	of daeth (Itam	23a) (Typa,		1	1.D		8M.	-		
State	1	11. Dete filed (Month, Day,	Yaar)	32. Re	gistrer's Signel	ture	*							
egistrar		DEC 0 1 1997	7	July Don	dron-Ran	dell-								
			- 1	1	The same of						_	-		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Vaar Fresia Alvarez 27 1997 2:32 AM November 4a. Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death Baltimore
If Undar 1 Yaar | If Undar 24 Hrs. Good Samaritan Hospital 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiaca (Stata or Foreign Country) Days Months Hours 1□M 2X F Vrs 83 215-78-0142 August 21,1914 Chile Usual Rasidanca of Dacedani 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 No Maryland N/A Baltimore 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 1625 Sherwood Avenue 21239 Chile 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican indian, Bleck, White, etc. 1 Navar Marriad 200 Married 1 ☐ Yas 2 🗶 No If Yas, Giva Yaar or Datas: Specify: Chilean 1 Yas 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 6 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Meldan Surnama) Federico Ester Vega 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1625 Sherwood Avenue Miss Berta Alvarez/Daughter Baltimore, Maryland 21239 20b. Place of Disposition (Nama of comatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 NOther (Spacify) Entonbrent Cementerio General No.#3 12/6/97 Iquique, Chile 21. Signature of Funaral Sarvica Licensea Brian A. Willem 22. Nama and Addrass of Facility Leonard J. Ruck Funeral Home, Inc Buan a. Willen 5305 Harrford Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onset and Death landionsula Diouse Immediata Causa (Final disaasa or condition rasulting in death) Due to (or es a conseguança of) Dua to (or as a consequence of) Dua to (or as a consequence of) Part fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 26. Plece of Daath (Check only ona) Hospital: 1 Inpatiant

Physician /Medical **Examiner**

permit. Pages Department of Important: If it eny injury or c

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

10a. Stata

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinal must be notified at

"naturel", or

Pages 1 end 2 should be filed within inner of Health and Mental Hygiene, ant: If item 27 is marked other than "I ury or other traumatic event, in a Max

the Meryland

72 hours after

Baltimore, Maryland 21215-0020

attending physician and for use as the buriel-tran Box 68760 P.O. signed b Records, page 2 s Division of Vital

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Sequantially list conditions, if any, laeding to immediate causa. Enter Undarlying Cause (Diseasa or Injury that initiated evants resulting in death) Last Physician/Medical Completed by 25. Wes casa referred to medical axaminar? Be 1 Yas 2 No Certification: To 27. Mannar of Deeth 1 Natural 5 Panding 2 Accident 6 Could not be datarmined 3 Suicida 4 ☐ Homleida edicai 29a Certifian

Examiner

29b. Signature and tale of certifier

invastigation

Certifying Physician: To the best of my knowledge, deeth occurred et the tima, dete end place, and dua to tha causa(s) and menner es statad.

| Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and menner statad.

28a. Data of fnjury (Month, Day Year)

29c. Licansa number D18589

28c. Injury et Work?

1 □ Yas 2 □ No

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

TOUSON MS D

28d. Dascribe how injury occurred

30. Nama and address of person who complated causa of death (Itam 23e) (Type, Print) CHARLES HATTON OSLEK DR 7600

31. Data filed (Month, Dey, Yaer)

DEC 0 1 1997

32. Registrer's Signatura chia Davidson-Randall

2ER/Outpatient 3□ DOA

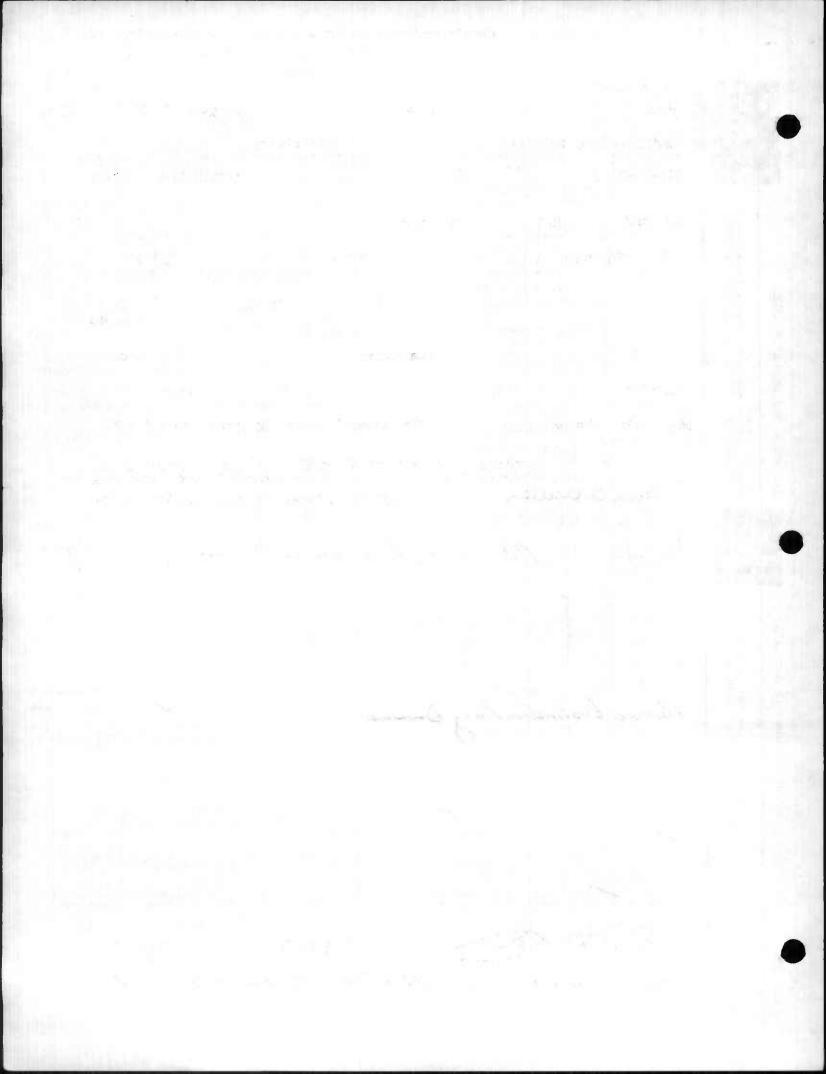
28b. Tima of

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

DHMH 16 Rav 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Daath 3. Time of Deeth Dey **Physician** Richard T Atkinson NOVEMBER 25 1997 00:05 HRC /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth Union Memorial Hospital Baltimore City
If Under 1 Yaar If Under 24 Hrs. Months Deys Hours Min. Month, 5. Sociei Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth (Month, Day, Year) **Funeral** Birthpleca (Stata or Foreign Country) 1⊠M 2□F Months Yrs. Director 57 212-38-1319 Apr 29, 1940 | Maryland Usuai Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 10d. Insida City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Arverne Ct. 21093 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Giva 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, atc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced Yaar or Detes: Unknown White Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 years 2 years Sales Management Automotive Sales 17. Fether's Name (First, Middle, Last) permit. Pages 1 end 2 should be filt.
Department of Heelth end Mental Hy
Important: if Item 27 is marked oth
any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be William Atkinson Laura Ward 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Gambino Atkinson (Wife) 21093 Timonium, MD 19 Arverne Ct. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation, Inc. 11-26 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 23a. Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, should, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel Cerebrovascular accident diseesa or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner multiple enboli Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disaese or injury that initiated events rasuiting in deeth) Last Due to (or es a consequence of): Ameroscheephic ceediovascular disease Physician/Medical Dua to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STAPHYLOCOCCUS MUREUS BACTEREMIA, HYPERTENSION by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed DIABETES MELLITUS, RENAL STONES **D808 2** 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medicel exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatlent 3 DOA 1 Yes 2 No 2 Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 番 28e. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigetion Neturei 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) end mennar steted. Medical 29e. Certifier (Check only one) 29b. Signeture and title of certifiar 29c. License number 29d. Dete signed (Month, Day, Year)

10

altimore, Maryland 21215-0020

Box 68760.

State 31. Dete filed (Month, Dey, Year)
Registrar

SUCHAR UNION MEMORIAZ HOSPITAL, BALTIMORE, MD 21218

1) 32. Registrer's Signature

17 Juni Davidson-Randelle

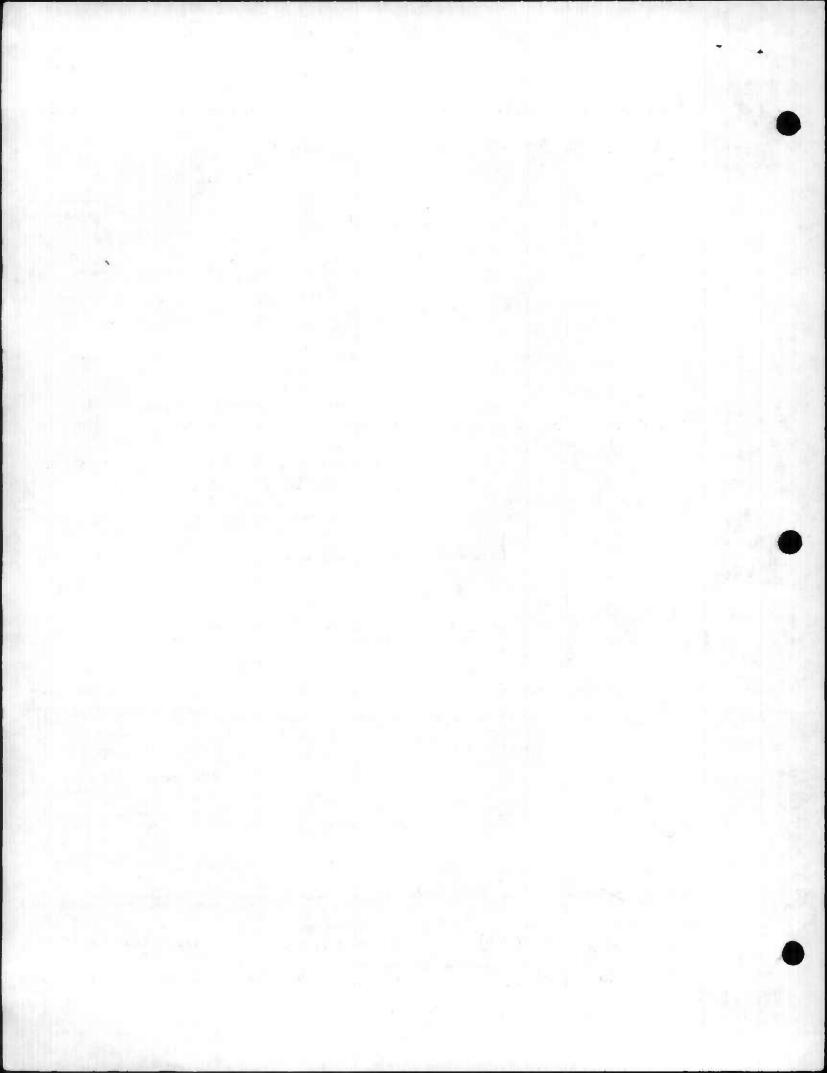
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NOVEMBER 25, 1997

N. Suchak, (MD)

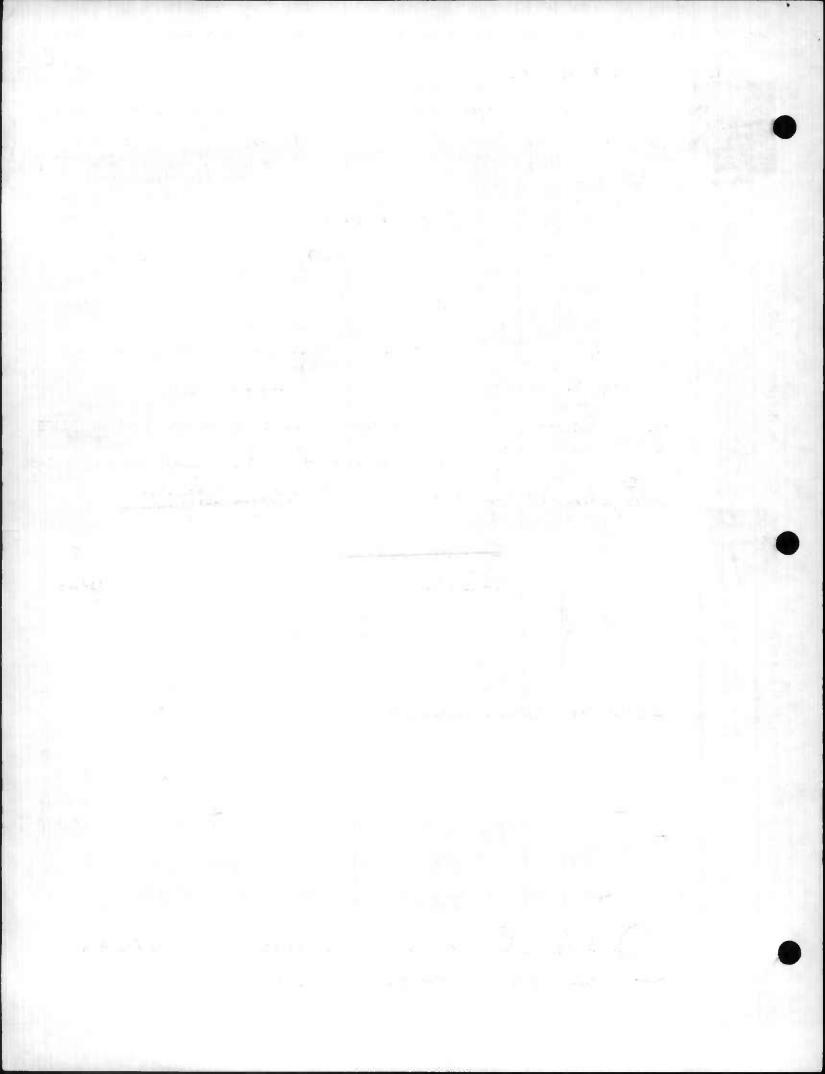
N.

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		1. Decedent's Name (First, Midd	1/26/97 EW le, Last)			tificate of	Dodin	2. Dete of De Month		Yeer	3. Time of Dea
sician edical miner	1	William Do			Sr.		4b. City, Town, or	Novembe		1997	8:30
eral tor		824 Berrymans 5. Social Security Number 218-16-9433	6. Sex	7. Age (In yrs. 73	. lest birthday) Yrs.	If Under 1 Year Months Days	Reisters Hours Min.	8. Dete of Bir	th y, Year)		ore ece (State or Fo y) yland
	-	Usual Residence of Decedent 10e. State 10b. County	1	10c. Ci	ity, Town or Loc	ation				10	d. Inside City Li
Director	010	Maryland Balti	more		Reist	erstown					1 ☐ Yes 2 🛱
		10e, Street end Number				10f. Zip Code			10g. Citizen of V		ry?
Funeral	0	824 Berrymans	12. Wes Dec	edent Ever In U	J.S. 13. W	2 J. 1		pecify Yes or No		S.A.	n Indian.
Ď	2	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	rled 1 TYPes If Yes, Gir	rces?	lf 1	Yes, specify Cub ☐ Yes 2 ☑ No	dispanto Ortgin? (Sen, Mexicen, Puert Specify:	o Rican, etc.)	Specify	ck, White, e	hite
Completed	bleten	(Specify only higher Elementery/Secondary (0-12)	nt's Education st grade completed)	1-4or 5+)	16a. Decede (Give k. life. De	ent's Usual Occup ind of work done O NOT use retire	pation during most of word d)	king	16b. Kind of Bu		
Con	5	12 Years 17. Fether's Name (First, Middle,	(act)		Produ	iction S	upervison		Black a		ecker
To Be C	5	Harry V.	Anderso	n			Marga	ret	Kelly		
7		19e. Informent's Name/Relations					end Number or Ru				
	1	Mrs. Mary Ande 20a. Method of Disposition 1⊠Burial 2 ☐ Cremation	3 □Removel from	State	Place of Disposi cemetery, creme	ition (Name of etory or other pla		Date	20c. Location -	City or Tow	m, Stete
OUCS.		4 □ Donation 5 □ Other (S 21 Signature of Funeral Service		Mou	22.	e Cemete Name and Addre	ss of Facility		Randalls		Maryla
	-	23a. Part1. Enterithe diseese, or shock, or heert failure. List	- M	ensa	87	28 Libe	yers Fune	Randal	lstown,		21133 Approximate
an cai ner		Immediate Cause (Final disease or condition resulting in death)	a.	UDDE	· De	4					Interval Between Onset and Deet
je	5				or as e consequ	ence of):					
Examiner		. /	JSC v	D					L	seas	
I Exar		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	5 b		or es a consequ	ence of):				4	gens
edical		Sequentially list conditions, if any, leeding to Immediate cease. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c	Due to (d						4	jens
edical		resulting in death) Lest	c	Due to (c	or es e conseque	ence of):	ven in Pert I.	23b. Did	tobacco use co	ntributa to	Jeans S
hysician/Medical		triat illitieted events	c	Due to (c	or es a conseque	ence of):	ven in Pert I.		tobacco use cor Yes 2周 No		
by Physician/Medical		resulting in death) Lest Pert II. Other algorificant condition	c	Due to (c	or es a conseque	ence of):	ven in Pert I.	1 🗆		3 Probe	ably 4 Unk
Completed by Physician/Medical		Pert ii. Other algnificant condition	d	Due to (c	or es a conseque	ence of):	ven in Pert I.	1 🗆	Yes 2,20 No en eutopsy rmed?	3 Probe	ably 4 Unk re autopsy findir lable prior to
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edical Certification: To Be Completed by Physician/Medical		Pert II. Other algnificant condition 25. Was cese referred to medice exeminer? 1	Hospital: Hospital: 1	Due to (compatible to the part of the part	DER/Outpatient 28b. Time of Injury ome, farm, streety) m 23e) (Type, P.	ance of): derlying ceuse gives a control of the co	26. Plece of Dearer: 4□ Nursing H y et k? Yes 2□ No	24e. Wes performent of the control o	en eutopsymmed? Yes 2 No one) dence 6 Other now Injury occurr Street end Numb wn, Stete) ceuse(s) and me date end plece, e	3 Probe 24b. Wer avail common of de 1 Prober (Specify) reed er (Specify) reed enner as stalend due to 1	Route Number, ted, the cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** NOVEMBER 28 1997 2:15 PM 4 REUBEN /Medical 4b. City, Town, or Location of Death 4e. Facility Neme (If not institution, giva street end number) 4c. County of Deeth Examiner HARBOR HOSPITAL BALTIMORE Ba If Undar 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) CENTER | thday) If Under 1 Yaar Baltimore City 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpiece (Steta or Foraign Country) **Funeral** Months Days 12 M 2 F 414-38-8178 72 **Director** 13, 1925 North Carolina Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinat must be notified at Maryland Baltimore City Baltimore 1 XYes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2755 Marbourne Ave. 21230 United States deeth 12. Wes Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours effer tent of Health end Mental Hygiena. Int: If Item 27 is marked other than "natural", or item 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Detes: 1942-44 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 ⊠ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Quality Control Inspector Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumame) William F. Butler Rachel Q. Smith 0 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Thomas / Companion 2755 Marbourne Ave., Baltimore, Maryland 21230 other 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete December 1 Buriel 2 □ Cremetion 3 □ Removei from Steta 6 Department of Important: If any Injury or ODCS. Crownsville MD Vet. Cem. 2, 1997 Crownsville, Maryland 4 □ Donetion 5 □ Other (Specify) of Funeral Service Licensee 22. Nama and Address of Fecility Kirkley-Ruddick Funeral Home, P.A. 21. Signatule 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23e. Pert1. Entar the disease, or complications that caused the deeth. Do not entar the moda of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death Physician /Medical tmmediate Cause (Finel BILATERAL PNEUMONIA disease or condition resulting In death) Examiner Due to (or es a consequence of) Examiner attanding physician end for use as the burial-tren Sequantielly list conditions, if eny, leeding to Immadiate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): P.O. ed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by I 30 Probably 4 Unknown 1 | Yes 2 | No Records, þ 24b. Were autopsy findings eveileble prior to Completed 24a. Wes en autopsy peeu completion of causa of deeth? pege 2 Yes certificate 2 No 1 ☐ Yes 2 No Division of Vital 25. Wes cese referred to medical Be 26. Plece of Death (Check only one) exeminer? Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 ☐ Yas 2 No 0 f inpatient 2 □ ER/Outpetient 3 □ DOA this funeral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After Neturel 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation efter death 3 Suicida 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital c To the Hospital within 24 hours or To the Funeral Completaly filled edical Cortifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier 29c. License number AS-2441614-A9 NOVEM BER 28 29b. Signature end title of certifiar 29d. Dete signed (Month, Dey, Year)

m.D.

32. Registrar's Signeture

HARBOR

when Devidson Randelle

HOSPITAL CENTER

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

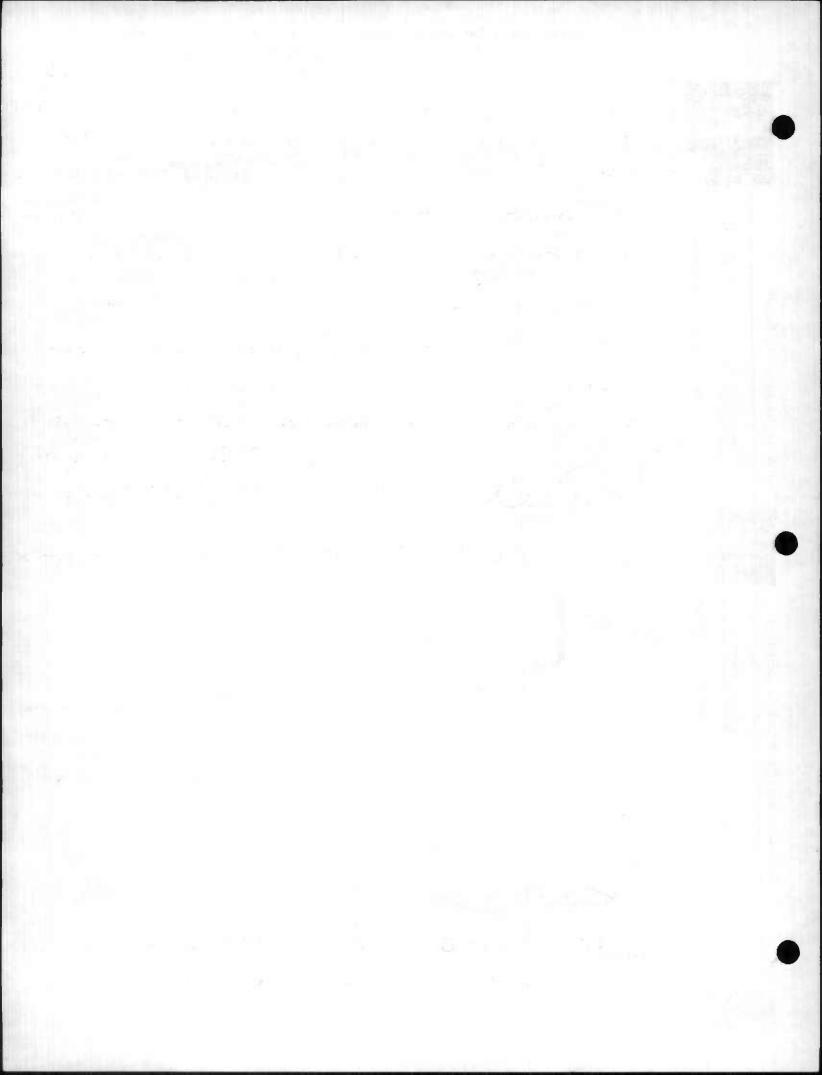
YUSH

PATEL.

State Registrar DR. PI

31. Dete filed (Month, Day, Year)

DHMH 16 Rev 6/95

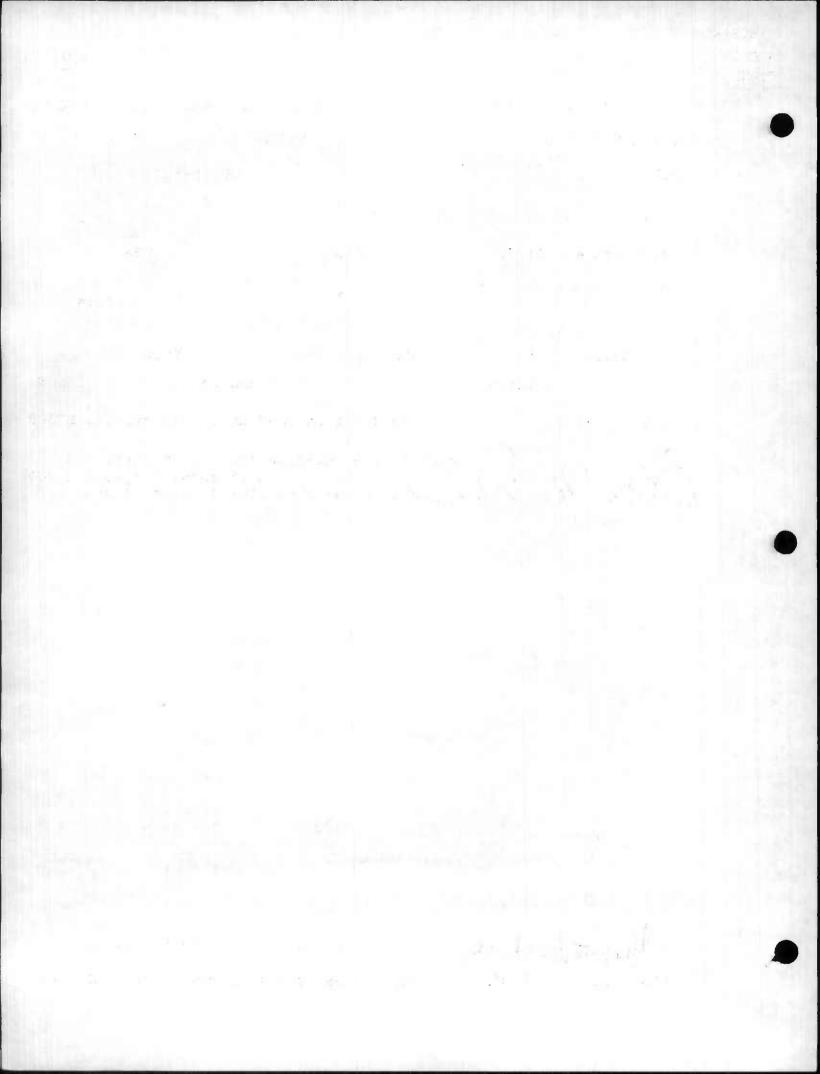


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MICHAEL BLAND It	ems	23a part I,27 per MEO		_		of Health and of Death	Mental H	ygieneg 7	35	920
Physic /Med			L. Bland				2. Date of D Month NOVEMB	ER 25,19		3. Time of Deeth 9:50 A.M.
Exam	ner	4e. Fecility Neme (If not institution, giv ST.JOSEPH HOSPITA				4b. City, Town, o			y of Deeth)RE
Funera Directo	-	5. Social Security Number 6. S 567-73-4879		s. last birthday) Yrs.	If Under 1 Months		S. 8. Dete of B			ce (Stete or Foreign
yland		Usuel Residence of Decedent 10e. State 10b. County	10c. C	ity, Town or Lo	cation				10d	I. Inside City Limits
vith the Marylan or 28a-f show	ctor	Md. NA	E	altimo	ore					¹ ▼ Yes 2 No
23a or 20	i Dire	10e. Streat end Number 7206 McClean	Blvd.		10f. Zip C			10g. Citizen of	Whet Country	?
tar des	y Funeral Director	11. Marital Stetus 1X Never Married 2 Merried 3 Widowed 4 Divorcad	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes ※ No If Yes, Give	1	Was Deceder	it of Hispenic Origin? Cuben, Mexican, Pue	Specify Yes or Norto Rican, etc.)		ce - American ck, Whita, etc	о.
21215-0020 d within 72 hours af giena. rr than "natural", or	Completed by	15. Dacedent's Ec	Yeer or Datas: lucation de completed)	16a. Deced	dent's Usuel (kind of work	Occupation done during most of w retired)	orking	16b. Kind of B		
2121 od within giena.	Compi	Elamantary/Secondary (0-12) 10th Grade	Collaga (1-4or 5+) NA		dent_	retired)		Stud	ent	
re, Maryland 212 s 1 and 2 should be filed within Health and Mental Hygiene. fem 27 Is marked other than other treumatic event, the	Be	17. Fether's Neme (First, Middle, Last)	nknown				ame (First, Middl Lzabeth	a, Meiden Surnai	na)	Bland
Taryla 2 should and Menter is market	To	19e. Informent's Name/Ralationship (19b. Mallin	ng Addrass (S	Street end Number or I	Ru <i>ral Rou</i> te Num	ber, City or Town	, Stete, Zip Co	ode)
1 and 2 Health a m 27 is		Maggie Sizer		209		tron Road	Apple			
Baltimore, permit. Pages 1 an Department of Heal Important: If frem 2 any Injury or other	(ABurial 2 Cremetion 3 C 4 Donetion 5 Other (Specify	Remove from State V C	shell WI	Mem. Nama end	Gardens Address of Fecility arch FH	12-01- Baltimo	re, Ma North	dalk, rylan Aven	Md. d 21202 ue
Physician /Medical Examiner). 	23a. Pert1. Enter the diseesa, or compshock, or heert failura. List only shock and the control of the control o	e. SEIZURE DI		ND ASTH		ac or respiretory	arrast,	- In	pproximata itervel Batween inset end Deeth
58760, icete be executed physician end s the buriel-transit	Examiner	Saquentially list conditions, if erry, leading to immediate cause. Enter Underlying Couse (Oisease or Injury	bDue to (or es e conseq	uence of):					
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Box 6 death certific	Physician/M	Pert II. Other significant conditions or		sulting in the ur	deriving cau	se given in Pert I	23h Die	I tohacco usa co	ntribute to th	ne cause of death?
P.O hat the od by the	by Phys		With Builty to County But Hot 10	suning in the di	luonying cau	given in react.		Yee 25 No		oly 4 ☐ Unknown
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of Vital Physician: T	o Be	eveminer?	Hospital: 1 ☐ Inpatient 2X	ER/Outpetien	t 3 DOA	Other:	aath (Check only Home 5 ☐ Ras	one) sidenca 6 □Ott	ner (Specify)	
ng ng	tion: T	27. Menner of Daath 1XX Neturel 2 Accident Investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c	Injury et Work?		how injury occur		
Division al or Attending as after death. at Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, stre	eet, factory, o	ffice	28f. Location City or To	(Street and Numi own, State)	ber or Rural R	oute Number,
To the Hospital o within 24 hours af To the Funeral DI completely filled is	edicai	29a. Certifiar (Check only one) 1□ Cartifying Phy 2 Typedical Example 100 (Check only one)	reiclen: To the best of my kni iner: On the basis of examin- end manner stated.	owledga, daeth etion end/or inv	occurred et	he time, dete end pled my opinion, daath occ	ca, end due to the curred at the time	ceusa(s) end m , dete end plece,	anner es state and dua to th	ad. a cause(s)
To the within 2 To the comple	Me	29b. Signefure end title of certifier	one manner states.		29c. L	icense number	T	29d. Date signe	d (Month, Da	y, Year)
		Mayrite B	effule			C.M.E.		NOVEMBER	26,19	197
		30. Name end eddrasslof parson who of	completed cause of deeth (Ite			Penn Stree	t, Balti	more, Ma	aryland	1 21201
St Regist	ate rar	31. Dete filed (Month, Day, Year)	32. Registrer's Sign	participal deser-	Pandelle.					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.₽ 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** 5: 15 aim ENNIE BUTLER NOVEMBER 24 199 /Medicai 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR CENTER BALTIMORE BALTIMORE HOSP ITAL If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5 Social Security Number 7. Age (In yrs. lest birthday) **Funerai** 1 M 2□ F 420-14-465 Director Usual Residence of Decedent 10a. Stete 10b. County 10d. inside City Limits "natural", or itams 23a or 28a-f show edical Examinar must be notified at 1 DYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hyglene.

ant: If Item 27 is marked other than "natural", or itams 23a or ury or other traumatic event, the Medical Examinations in Completed by Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Yeer or Dates: U.U.T. 11. Marital Status Bieck, White etc. 1 Never Married 22 Married 21215-0020 1□ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuai Occupation (Give kind of work done during most of working life_DO NO vuse retired) 15. Decedent's Education fy only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland 17/ Father's Neme (First, Middle, Last) Be 19a. Informant's Name Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or ebilA Thrs. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 23e. Perrit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart tellure. List only one ceuse on each line. Approximete Interval Between Onset and Death Physician /Medicai Immediate Ceuse (Final PNEUMONIA disease or condition resulting in deeth) **Examiner** Physician/Medical Examiner STENT PLACE MENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last FAILURE 2 HTMOM The law requires that the death certificate Due to (or as e consequence ot). P.O. Box MONTHS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No THORACO CENT Division of Vital Records, þ Be Completed 24b. Were eutopsy tindings evaileble prior to completion of cause ot deeth? 24e. Was an autopsy performed? HYPERTENSION 20 No 1 ☐ Yes 2 ☐ No DIABETES MFILLITUS or Attending Physician: 25. Was case reterred to medicei exeminer? 26. Piece of Deeth (Check only one) Hospital: Hospital: 2 EP/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural death. 1 Tes 2 No 2 Accident To the Hospital or Attend within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AC 2441614 N: Sow Jan NOVEMBER 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) SOW I ANYA NAGABHIRAVA, HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST, BALTIMORE, M.D.

DHMH 16 Rev 6/95

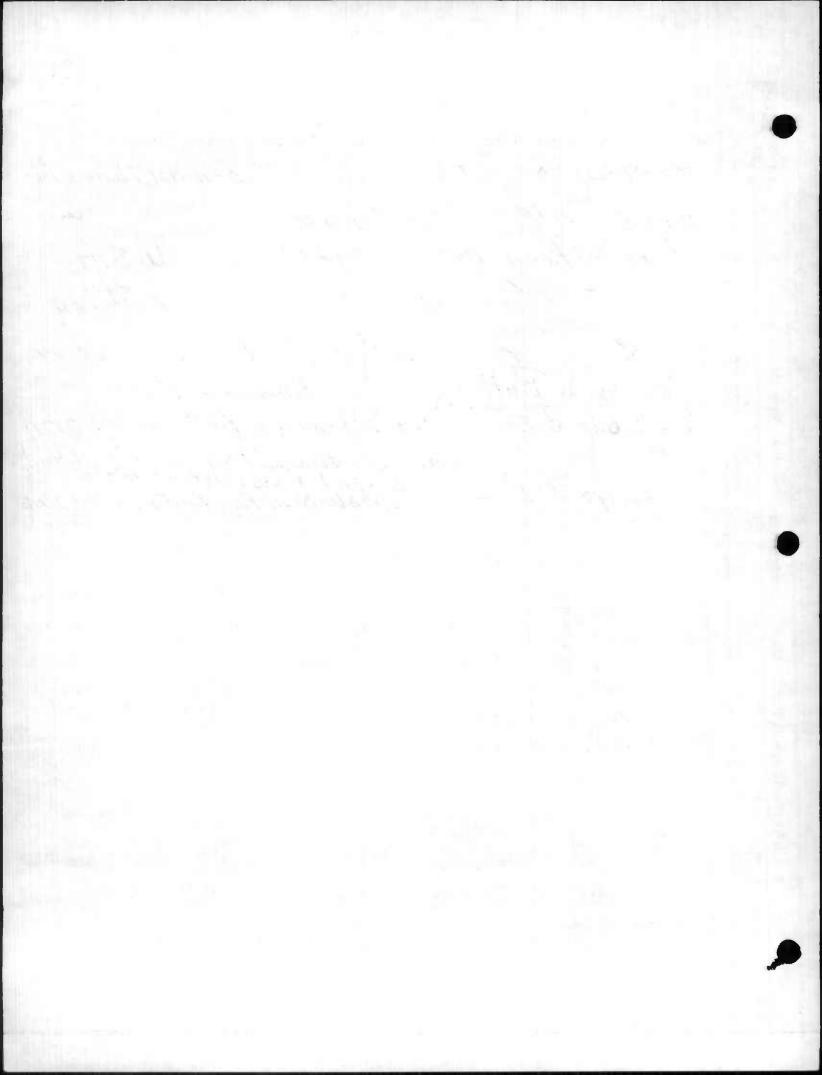
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31. Date filed (Month, Day, Yeer)

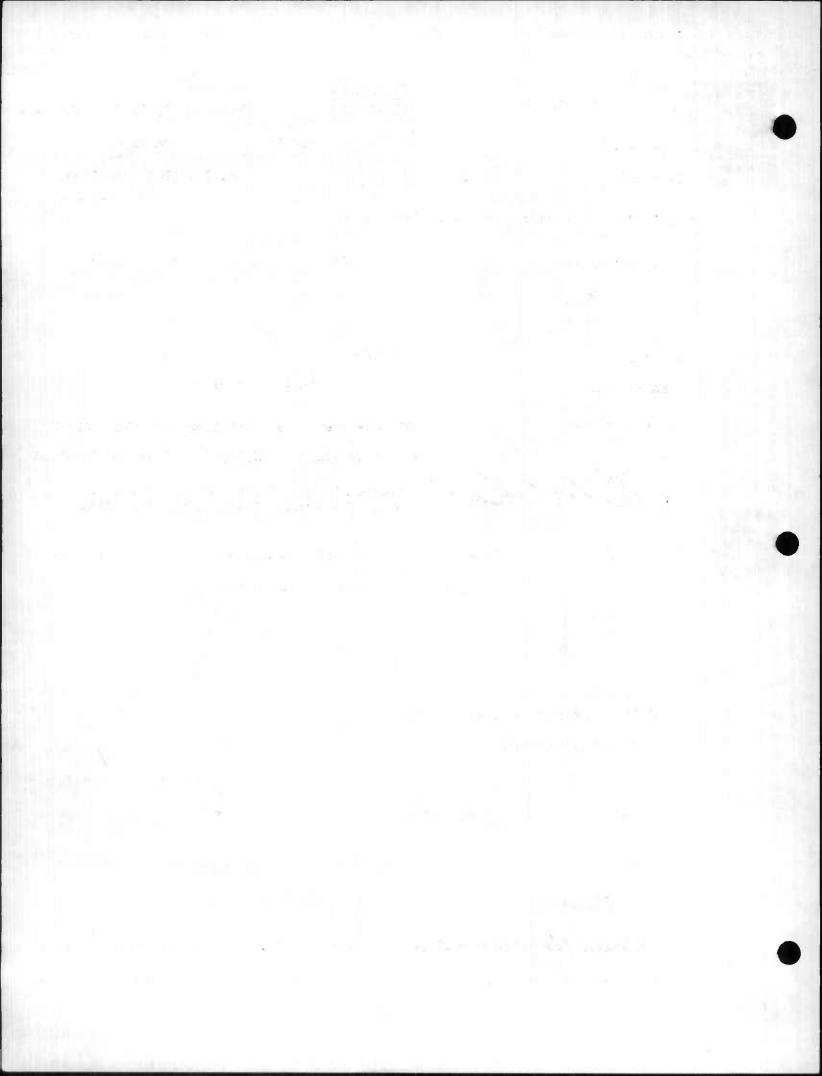
32. Registrar's Signature

a surdson-frandall

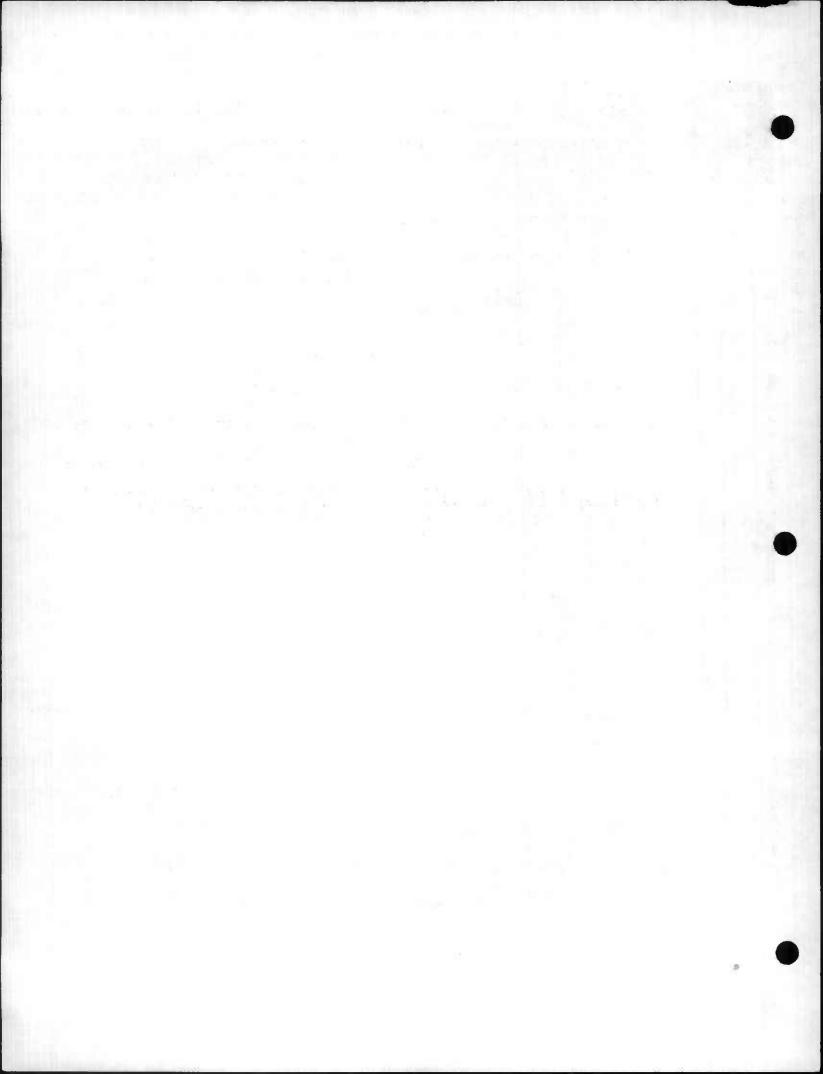


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Comp	Ž	29b. Signatura and title of certifier			2:	c. Licans	a number	-	29d. Data signe	d (Month, Day, Year)	
		27.	somo	nes		4	04048	-0	Dear	mlar 1, 19:	97
XI	-	30. Nama and address of person who co	omplated cause of death	(Item 23e)	(Type, Print)	76	672	Bela in	nd	annar as stated. and dua to tha causa(s) d (Month, Day, Year)	
1		FERNANDO	U. FERRA	o me)	3	alto	1210	21236		
	0	31. Date filed (Month, Day, Year)	32. Hagistrar's	Signature	ron-Randa	22					
Stat Registra		DEC 0 11	dal Pan	Art lance for	Mar. all .						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month NOV **Physician** 05:00 26 1947 Theresa Booker /Medical 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1405017 Baltimore If Under 24 Hrs. 8. Dete of Birth 9. Birthplace (State or Foreign Min. Min. April 24, 1942 Pennsylvania If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 □ M 2 🛣 F Days Yrs. 186-32-9767 55 **Director** Usuei Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner mant be notified at 1 Yes 2 No Maryland None Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4023 Colborne Rd. 21229 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: p 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Rusiness/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) ARA Food Service Food Service permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Cheeks Johns Jasper Grantham Roena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4023 Colborne Rd. Baltimore, Maryland 21229 Todsha Jones / Daughter 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Duriei 2 Cremetion 3 Removel from State Garrison Forest 12-1-97 Owings Mills, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Opensee 22. Neme end Address of Fecility The Derrick C. Jones Funeral Home 21215 4611 Park Heights Ave. Balto., Md. 23a. Part1. Enter the disease, or complications that any set the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** Congestive Heart Failure Due to (or as a consequence of): - Schemiz Heart Disease /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of) Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 YUnknown Insulin Dependent Dinbetos Mellitus 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospitai: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28h. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending Investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 De Certifying Physician: To the best of my knowledge, death occurred at the time, date end piace, and due to the ceuse(s) and menner as steted.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end manner steted.

Medral Resident

30. Name and address of person who completed cause of death (item 23e) (Type, Print) St. 45 nes Hospital

Michael Praffie, m.D. 900 Caton Ave Bultimere

29c, License number

P11079

29d. Date signed (Month, Dey, Year)

ME; Theresa M. Booker Division of Vital Records, P.O. Box 6

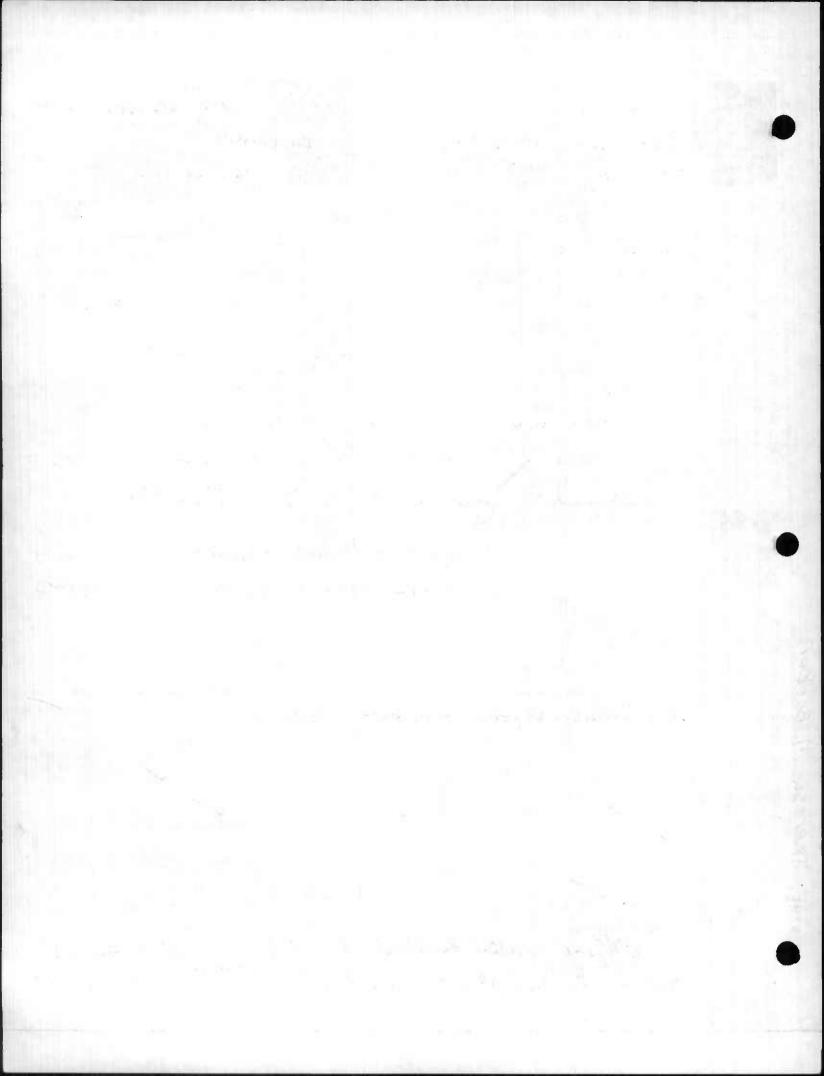
Baltimore, Maryland 21215-0020

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signeture end title of certifier



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle Last) 2. Dafe of Deeth lovember 2 ROBERT MAITLAND BARNETT 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Baltimore Timonium 2408 Ravenview Road If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year)
Dec. 8, 1930 If Under 1 Yaar 5. Social Securify Number 7. Aga (In yrs. last birthday) 9. Birthplece (Stata or Foraign Months Deys 1 X M 2 F Maryland Yrs. 248-48-6186 Usual Residence of Decedant 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Timonium Maryland 1 ☐ Yes 2 No Baltimore 10f. Zip Code 10g. Citizen of Whef Country? 10e. Streef end Number 21093 2408 Ravenview Road USA 12. Wes Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Bace - Amarican Indian. Black, White, efc. 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: Peacetime

1 □ Yas 2 ☒ No Specify: 1 Never Merriad 2 Married 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) 5+ Elementary/Secondary (0-12) Physician Medical 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Helen Robert M. Barnett 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Timonium, Maryland 21093 2408 Ravenview Road Mrs. Efie R. Barnett (Wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from Stete Greek Orthodox Cemetery 11/29/97 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Fyneral Service Licenter 22. Nama and Address of Facility Towson, Md. 21204 Ruck Towson Funeral Home, Inc. 1050 York Road concal tok 23a. Pert Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) 10SC/exoTIR Due to (or as e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as e consequence of) Due to (or es a consequence of) resulting in death) Lesi Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner physician end is the burial-trans attending p for use es 80 ed by the a

Examiner Physician/Medical signed t þ Completed peed certificate has b director, Be 10 this After thi funeral Certification:

Physician

/Medical

Examiner

Funeral

Director

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1 and 2 should be filed within 72 ho Haaith and Mental Hygiena. 8m 27 is marked other than "natur ither trsumatic event, the Medical

permit. Peges 1 and 2: Department of Haaith at Important: If item 27 is any injury or other trau

Physician /Medical Director

Funeral

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72 hours after death

Baltimore, Maryland 21215-0020

The law requires that the death certificete be assecuted Box 68760. Division of Vital Records, P.O. or Attending Physician: deeth. Director: after within 24 hours aft To the Funeral Di completely filled in

To the P within 2

edical

27. Manner of Death

1 Maturei

2 Accident

3 Suicida

29e. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

5 Panding

investigation

6 Could not be determined

State Registrar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Baltimo 32. Registrer's Signature Pandelle narles 31. Dete filed (Month, Day, Year) DEC 0

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dafe and piece, end dua to the ceuse(s) end manner as stated.

2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and manner stated.

29c Licensa number

1 Yas 2 No

28b. Time of

28e. Piece of Injury - At home, farm, sfreef, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date sign#d (Month, Day, Year)

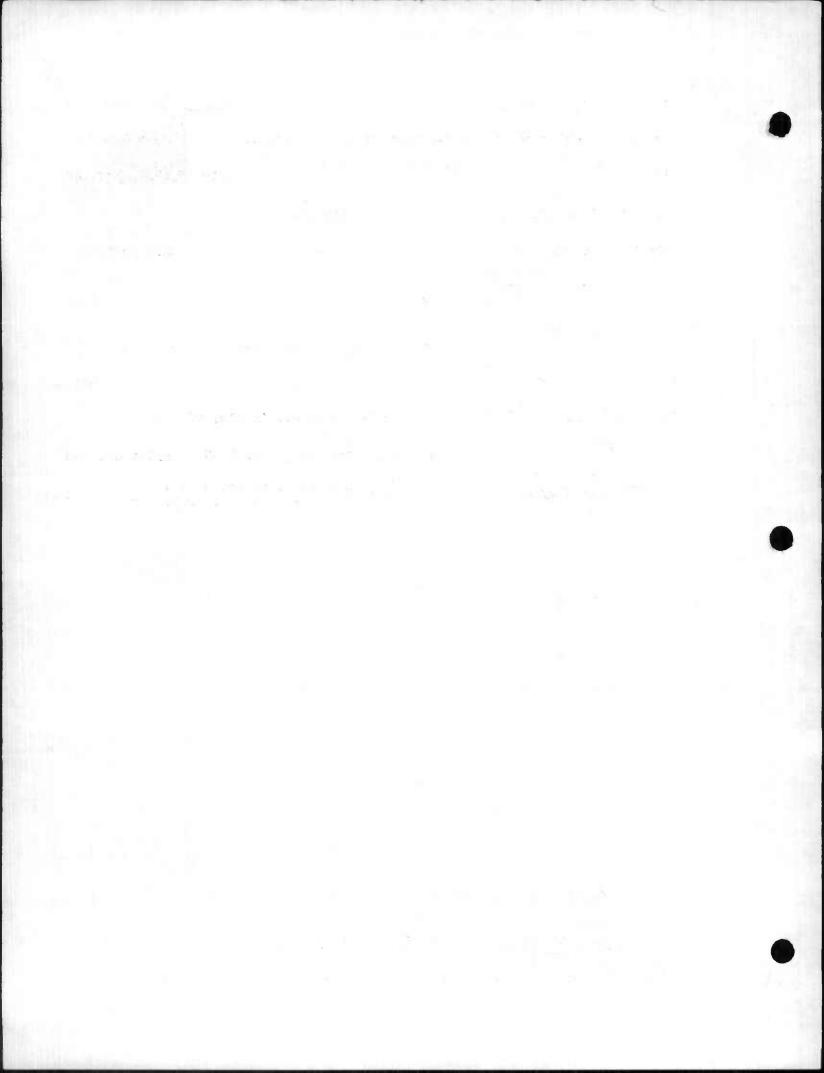
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28e. Dete of Injury (Month, Dey Yeer)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Cartificate of Death

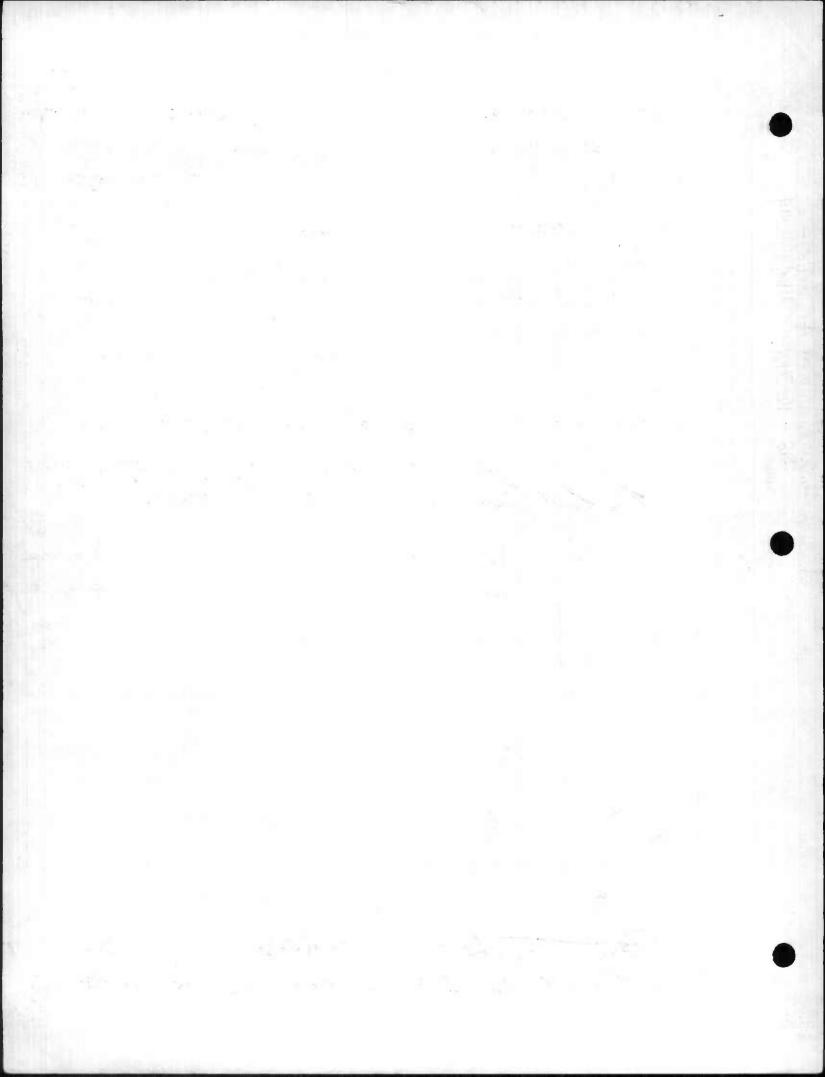
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Physician	_	Robert R.	Bozzell					Month Novemb	Day	Year 1997	12:45A
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d out	3	17. Father's Name (First, Middla, Last) James Bozze	1.1					ma (First, Middla,	Maidan Suman	,	
To Men	2						Georg:				elton
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any Injury or other traumatic event, the M once. To Be Comp		19e. Informant's Name/Ralationship (7 Paulette L. Bozze	11 / Wife		1059 B	& A	Blvd., Al				ida)
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nding physicians as the bu		rasulting in death) Last	d	to (or as a	consequance o	f):				t	
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igned by the attendii be detached for use by Physician/		art ii. Other significant continuons co	mileuting to death but h	ot rasuming	in the uncarrying	y causa g	ivan in Fanti.		res 2 No		-1
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		DO. Nama and addrass of person who co	Attenday	Do	ctal	D.	21684		11.28	.87	
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	2	MARTIN G. BACON						MARIE	GROSS			
100		19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Ma	ailing Address (Street an	d Number or Rui	ral Route Numb	er, City or Town	, Stata, Zip (Code)	
n 27		WINIFRED T. BACON,					E, OCEAN	CITY,	MARYLAN	D 2184	12	
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i ga	Certification:	- I nomicioa	building, atc. (Spa	iciny)				City or To	WII, State)			
		29a. Certifiar 12 Certifying Phy	efcfen: To the best of my	nowladge, da	ath occurred at	tha tima,	, data and place,	and due to the	causa(s) and m	anner as ste	eted.	
E 9 :	edicai	(Check only 2 Medical Exami	ner: On the basis of axam and mannar stated.	ination end/or	Invastigation, Ir	n my opin	nion, daath occur	red at the time,	data and place,	and due to	tha ceuse(s)	
	_	29b. Signature and title of certifier			29c. l	License r	number		29d. Data signe	ed (Month, D	Pay, Year)	
		1	0 ()			42	626		11/10	10 A		
E 4		Plan >	10000		4	1			1/11 8 1			
SE 6		30. Name and addrass of person who co	ompleted causa of death ()	tam 23a) (Tvo	pe, Print)	()	0,6		11/81	57	14	
EF C		30. Name and addrass of person who co	ompleted causa of daath (I	tam 23a) (Typ	De, Print)	7/4/	WAY I	R	BERL,	10, /h	1021811	

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middia, Last) 2. Date of Death BRAVAIA **Physician** ENTA NOVEMBER 28, 1997 9:00AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7080 CRADLEROCK WAY 5. Social Security Number 6. Sax COLUMBIA If Undar 24 Hrs. 8. HOWARD 7. Age (In yrs. last birthday) If Undar 1 Yaar Birthplace (State or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funerai** 10 M 20 F Min Months Days Hours 216-31-0385 Director 91 OCT. 20, 1906 RUSSIA Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City. Town or Location ne 23a or 28a-f show 10d. Insida City Limits Director 1 Yas No COLUMBIA MARYLAND HOWARD 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 21045 RUSSIA items 23a 7080 CRADLEROCK WAY Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puarto Rican, atc.) 14 Bace - American Indian Black, Whita, etc. 1 Navar Married 2 Married natural, or 1 ☐ Yas 2 No Specify: P 3℃Widowed 4 Divorced WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry el Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy Important: If Item 27 is marked oths any Injury or other traumatic event 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be RAKHIL SIMKIN JOSHUA SIMKIN 2 19a, informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 7429 SWANPOINT WAY, COLUMBIA, MARYLAND 21045 JOSHUA BRAVY, SON 20a. Mathod of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata cematary, cramatory or other place) Burlal 2 Cremation 3 Ramoval from State 11/30/97 COLUMBIA, MARYLAND COLUMBIA MEMORIAL PARK 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Death Physician PROTAL ARREST Dua to (or as a consequence of): DUANU ARTERY PISEASE Dua to (or as a consequence of): Immediata Causa (Final disease or condition rasulting in death) /Medicai Examiner Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaase or injury Physician/Medical that initiated evants resulting in death) Last CARDIAL FAILURE Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? PRRTENSION 1 Yes 2 No 3 Probably 4 Onknown by 24b. Wara autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed? Be 10 Certification: 27

The lew requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, P.O. 2 Records, Division of Vital To the Hospital or Attend within 24 hours efter deaf To the Funeral Director; completely filled in by the

death

hours after

altimore, Maryland 21215-0020

Was casa rafarred to	medicai				28. Placa of De		□ Yas niv ପ#ଣୀ	2 11 0	1 🗆 Yas	2□ No
examiner?		Hospital: 1 ☐ Inpatiant 2	☐ ER/Outpatient 3☐		na 5 Aasidance 6 Othar (Specify)					
Manne of Death 1 □Natural 5 [2 □ Accidant	Panding Invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28c.	Injury at Work? 1 Yas 2 No	28d. Descri	be how i	njury occurred	d	
3 Suicide 6 (4 Homicida	Could not be datarmined	28a. Placa of Injury - At building, atc. (Spec	home, farm, street, fact	28f. Location (Street and Number or Rural Routa Number City or Town, Stata)						

29b. Signature and title of certifier

29c. Licensa number

29d. Date signed (Month, Day, Year) 11 (28(97

30. Name and address of person who completed causa of daath (Itam 23a) (Type, Print) R. KAPLAN JEFFRE

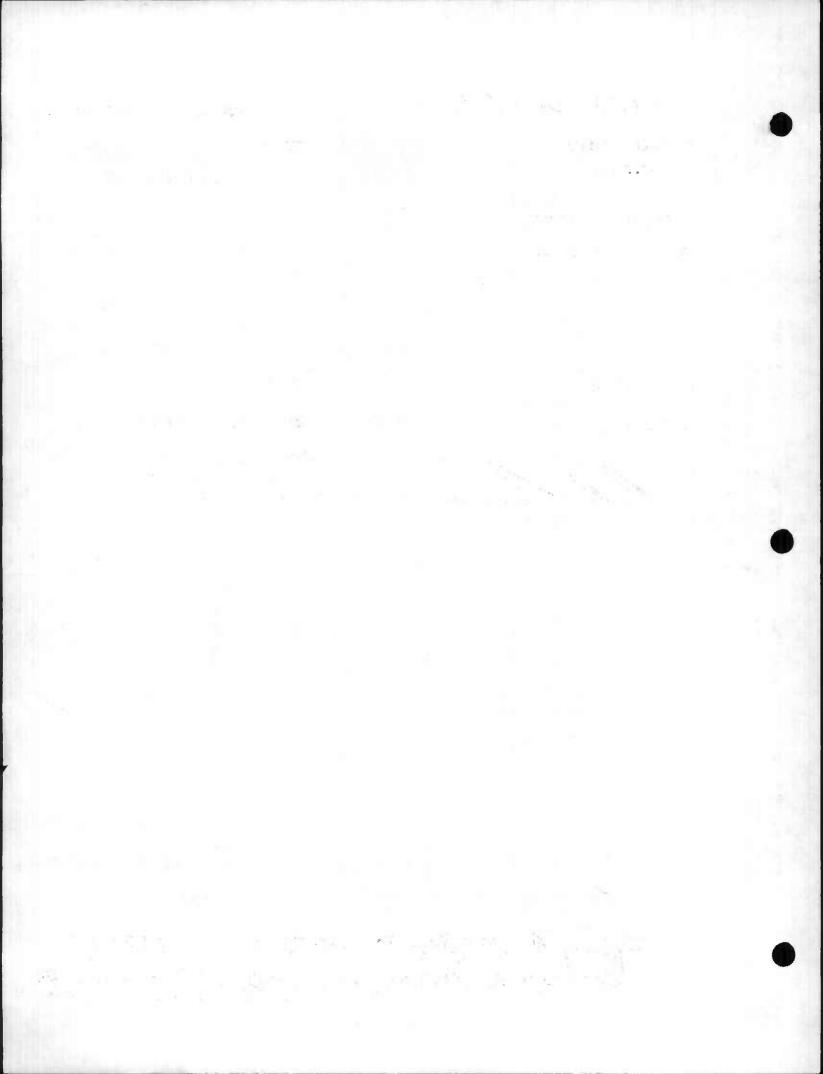
4801 DONSEY HARL DE

State Registrar

edicai

31. Date filed (Month, Day, Year) DEC 0 1 1997

32. Registrar's Signatura Julia Davidson-Randsee



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Movember 25, 199 1/8 heresa or Mis /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cify 8. Date of Birth (Month, Day, Year) 105Pital 7. Age (In yrs. last birthday) Maryland Gregera Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) **Funerai** 1□ M 2X F Months Days Hours 108-22-8466 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2401 USA Brook tield 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) tresser Cleaner 12 traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Pages 1 end 2 should be nent of Health and Mental William Kachae Nea 0 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MD21133 Konald Ko mportant: If item 27)amose 000 other altimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place 00 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem Park 13 22. Name and Address of Facility

A. Morton ature of Funeral Service Licensee Sons Funeral in, Balto MD 21217 1701 ames aurens 23a Far 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, buck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** travascular Cuagulation /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the bunel-tran Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last The law requires that the death certificate be execut Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): ate has been signed by the attending page 2 should be detached for use as Part It. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Were autopsy findings avallable prior to completion of cause of death? Completed 24e. Was an autopsy performed? this certificate 1 Yes 1 Yes 2 No Attending Physician: Be (director, 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A death 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who conholeted ceuse of death (Item 23a) (Type, Print)

State Registrar Nattakom

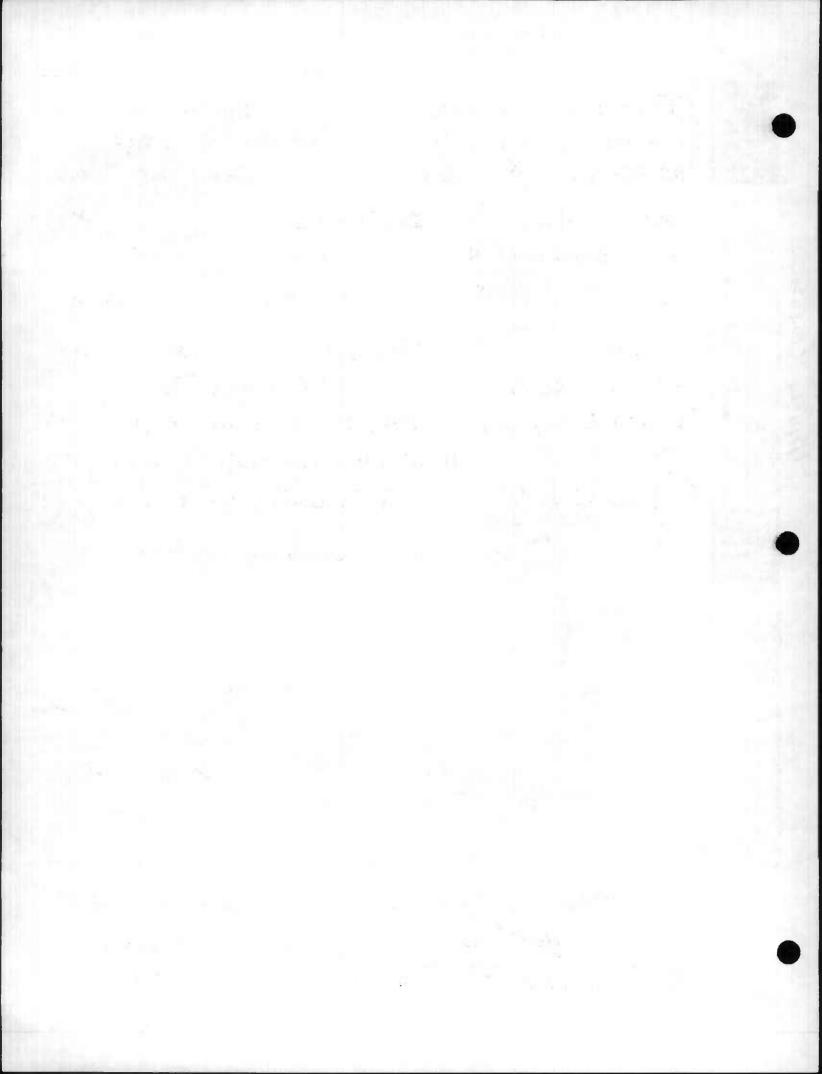
32. Registrar's Signature

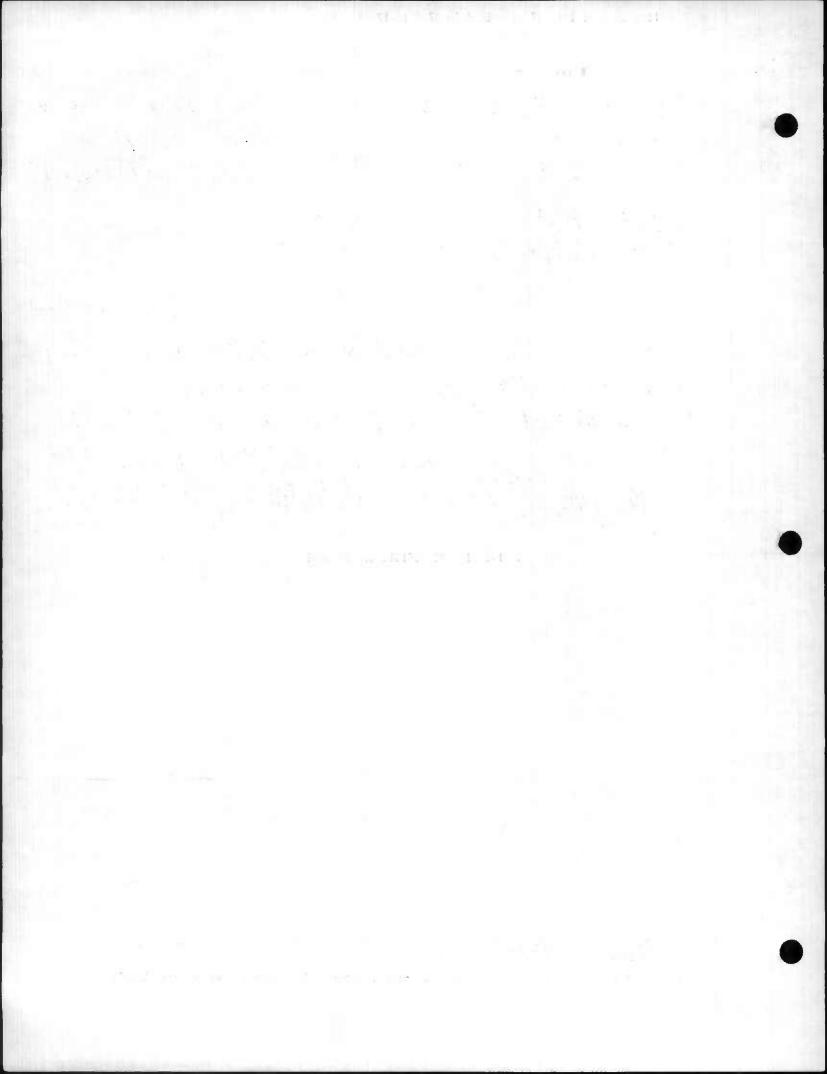
ul Davidson

31. Date filed (Month, Day, Year)

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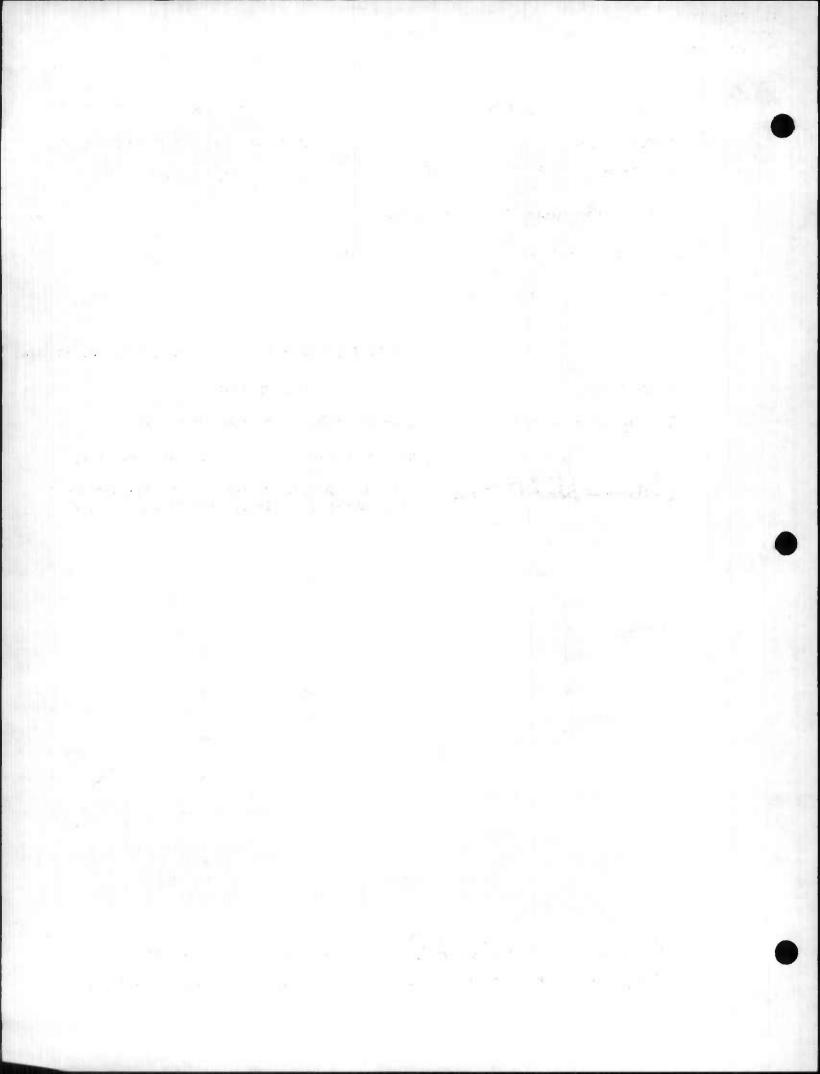
DHMH 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	par	t I II 27 28a-f per ME 1. Decedent's Name (First, Middle, La		dh Certif	ficate of	Death	2. Date of De	Reg. No.		Time of Death
Physic		Paul	Castagna				Month	Day	Year	215AM
/Medi Examir		4a. Fecility Name (If not institution, giv				4b. City, Town, or				ZIJAN
Funeral Director		007 44 0100	Sex 7. Age (In yrs		f Under 1 Year lonths Deys	ROCKVII.I If Under 24 Hr. Hours Min	8. Date of Bi (Month, D	th		(State or Foreign
fand		Usual Residenca of Decedent 10a. State 10b. County	10c. C	ity, Town or Locati	ion				10d. lr	nside City Limits
Mary First	tor	Md. Montgom	mery Co. Ro	ckville						Yes 2 XNo
of the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Whet Country?	
th will		#4 Monroe Street	#703		20850)		USA		
be filed within 72 hours efter death with the Maryland the Hygiene. Ide Hygiene. Ide other than "natural", or flame 23a or 28a-f show other than "natural", or flame 23a or 28a-f show event, the Medical Eratural must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad	12. Wes Decadent Ever In U Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Yeer or Dates:		Decedent of I es, specify Cub Yes 2 No	Hispenic Origin? (en, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		e - American Inck, White, etc.	
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	fucetion	16a. Decedent	's Usual Occu	pation during most of we	orkina	16b. Kind of Bu	usiness/Industry	/
Hygiene. ther then ent, in a Mar	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retire	nd)	arking			
other t	0	17. Father's Name (First, Middle, Last)		Crisi	s Inter	rvention	ıme (First, Middle		-	Hotline
and Mental by marked or umatic eve	o Be					Rita Ro		, Maiden Suman	10)	
mark mark	2	Frank Castagna 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	Address (Street	tand Number or F		er, City or Town.	State, Zip Cod	9)
27 ia		Frank Castagna -				Rd., Gler			545	-/
Itam othe		20a. Method of Disposition		Place of Dispositio	on (Name of		Dete	20c Location -	City or Town, S	State
int: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ly Road		ry	12/03/97	Westbu	ry, N.Y	· .
Department of Heelth end Menta Important: If Item 27 Is marked any Injury or other traumatic ex once.		21. Signature of Funeral Service Lean 23a. Part1. Enter the disease, or com shock, or heart failure. List only		Gary	L. Kau	ess of Facility	neral Ho	ma at Ma	adowrio	43
hysician /Medical xaminer	ner	Immediate Cause (Final disease or condition resulting in death)	a. ASPHYXIA Due to (or as a consequer	nce of):					
physician and s the bunel-transit	i Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury		or as a consequen	nce of):					
ding physic se es the b	Medicai	that initiated events resulting in death) Last	Due to (d	or as a consequen	ce of):					
ettending for use es	cian	Dati Character Was a state							_1_	
igned by the e be deteched f	by Physician/M	Part II. Other eignificant conditions of COCAINE INTOXICATION		sulting in the under	riying ceuse gr	ven in Part I.		tobacco use con Yes 2□ No		d Unknown
has been sig ge 2 should b	Completed b	Part E						an autopsy ormed?	availabl	utopsy findings e prior to tion of cause
	Com						1	Yes 2□No	Yes	2 □ No
certificate rector, per	Be	25. Was cese referred to medical examiner?					ath (Check only	one)	1	
	2	1 X Yes 2 No		1	3LI DOA		Home 5 Res			
h. After funer	ion	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occur	red	
fter deet lirector: in by the	Certification:	2 Accident 3 XX Suicide 4 Homloide	100110 11/30/31	ome, farm, street.		Yes 2XXNo	20f Location	ut plastic Street and Numb wn, State) 4 Mc	ar or Dum / Do	to Alumbar
thin 24 hours a the Funeral D mpletely filled	edicai ((Check only) 2 Medical Exam	ysician: To the best of my knoninar: On the basis of examina	owledge, death ocation and/or invest	curred at the ti	me, date and plac	e, and due to the	cause(s) and ma	inner as stated	ceuse(s)
within 2 To the F complet	Med	29b. Signature and title of certifier	and menner stated.							
₹ ° °		200. Signatura and mile of cultural	Lordo 1	Au	29c. Licens			29d. Dete signe		
		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Prin		C.M.E.		NOVEMBE	ER 30,	1997
		2110	KE MD			eet, Bal	timor	Marriana	21201	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item #7, #8 perFH G754 12/9/97EW Certificate of Death Item: 7, per F.H. G-754 12/1/97 reb 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician JAMES** CHARLES Anne Aundel
2/13/11 9. Birth · /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Annapolis Home Nursing Hanapohis If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Hours Min. Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days South Cotolina 10 M 20 F 250-03-145 Director Usual Residence of Decedent 10d. Inside Olty Limits 10a. State 10b. County 10c. City, Town or Location the Marylet 77 is marked bither than "natural", or itema 23a or 28a-f show treumatic event, the Medical Exertiner mant be notified at Anne ARundel 1€ Yes 2□ No Annapolis Maryland. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Dean Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 II/Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after nend Mental Hygiena. Is marked bither than "natural", or its Specify: BL 1 ☐ Never Married 2 ☐ Married ack Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown UKnowin 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Charles Hewart Hammie 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 st Department of Health end important: if item 27 is n any injury or other traun pace. Annapolis Norsing Home Van Buren Street 20b. Piace of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State etho (renator 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Fagility Approximate Interval Between Onset and Death 23a. Pagl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or conditi-resulting in death) neumonia Examiner Due to for es e consequence of). Examiner wenuc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence physician certificata be Physiclan/Medical Due to (or es e consequence of): 80 950 for signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings avalleble prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4√√ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 1 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funaral 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 27. Manner of Death 28c. injury at Work? Certification: 5 Pending Investigation 1 2 Neturai 1 Yes 2 No 2 Accident efter deet Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide 9 Hospital of Purious Purious D 1X Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end manner as steled.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical taly (Check only one) within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

pleted cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

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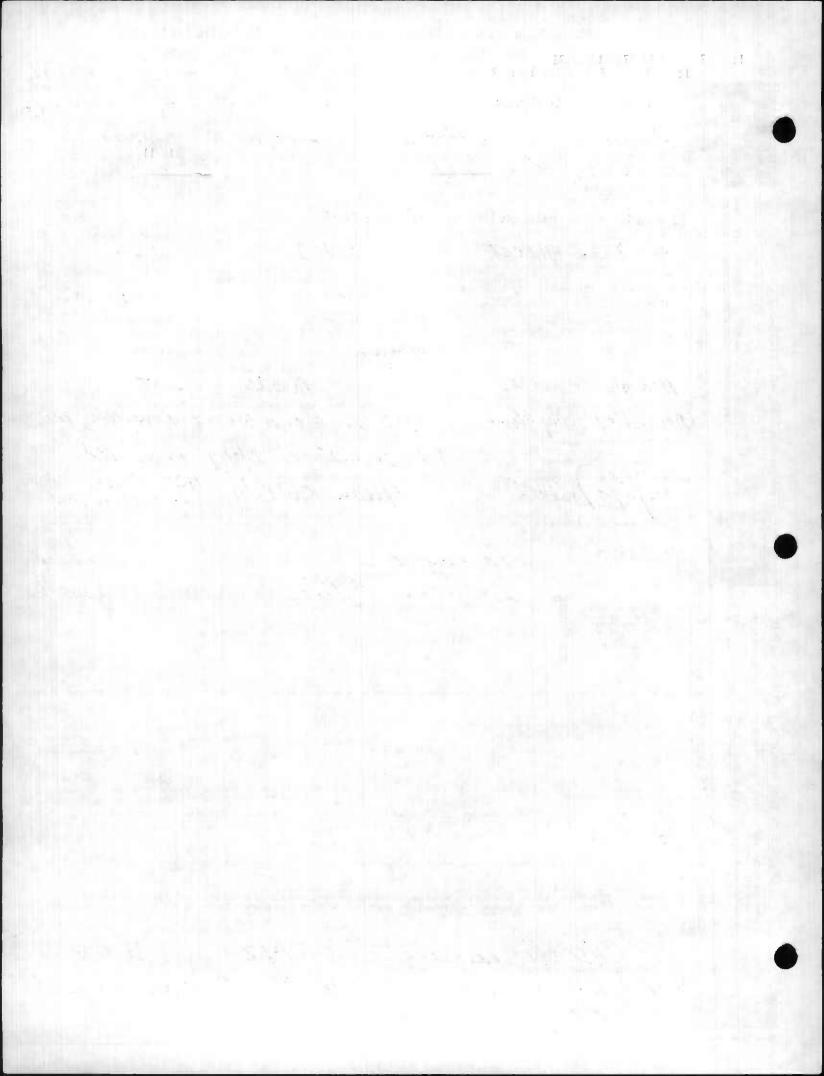
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State Registrar 30. Name and address of berson

31. Date filed (Month, Day, Year)

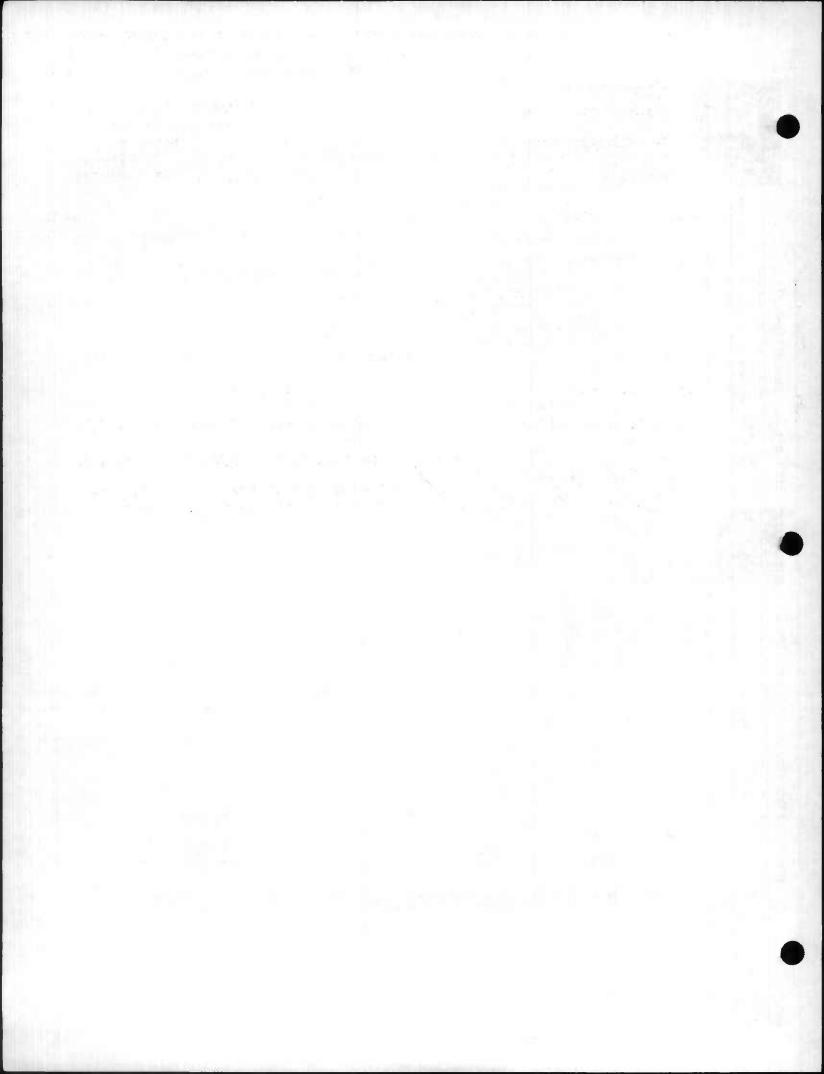
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	_	Decedent's Name (First	it, Middle, Li	ist)				f Death		2. Date of De	Reg. No. 🛩		593
sician	_	Edmund Wa	alter	Cross					- 1	Month Novembe	er 24, 1	1997	8:00
edicai miner		4a. Fecility Name (If not in			umber)			4b. City, To	wn, or Lo	cation of Deetl		y of Death	
	ı	2820 Salish	oury A	venue				Edgeme	ere		Balt	imore	
rai	1	5. Sociel Security Number		Sex	7. Age (In yrs.	last birthdey)	If Under 1 Yes	ar If Under	24 Hrs.	8. Date of Bir (Month, De			ace (State o
tor		217-26-2234		10 M 2□ F	66	Yrs.	Months Day	s Hours	Min.	pr. 15			yland
	-	Usual Residence of Dece										JI Maryla	
	- 4		County			ty, Town or Lo						11	Od. Inside Ci
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eted by Funeral Director		Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code							10g. Citizen of	Whet Coun	try?		
100		2820 Salisbu	ary Av	enue			21219	9			United	State	29
Funeral		11. Maritel Status		12. Was Dec	cedent Ever In U	J,S. 13.	Was Decedent of If Yes, specify C	f Hispanic Or	igin? (Spe	cify Yes or No	14. Rec	ce - Americ	en Indian,
正		1 Never Married 2	Married		2 No		1□ Yes 2□N			nosii, etc.)			
1 by		3 ☐ Widowed 4 ☐ □	Year or I	Detes: 1940		10 169 2CX	о эрвопу.			Specif	whi	te	
Completed		15. D (Specify onl	ecedent's E	ducetion ade completed	1952		dent's Usual Occ	cupation	at of working	na	16b. Kind of B	usiness/inc	lustry
de		Elementary/Secondery	-		(1-4or 5+)	life.	kind of work dor DO NOT use ret	ired)					
S		12 Years				Mil	lwright					Steel Industry	
Be		17. Father's Name (First,		,				18. Moth	er'a Neme	(First, Middle,	, Maiden Sumar	faiden Sumame)	
2		Walter E. Cr						Mar	ie Te	ller			
		19a. Informant's Name/R	elationship (Type, Print)		19b. Meilir	ng Address (Stre	et and Numb	er or Aura	Route Number	er, City or Town	, State, Zip	Code)
		Linda G. Cro		ife)			Salisbu	ry Ave	nue	Baltim	ore, Man	ryland	1 2121
	2	20a. Method of Disposition 1 ☐ Burlal 2 ☐ Creation		Bomovel from		Place of Dispo cemetery, crer	sition (Name of matory or other p	olace)		Dete	20c. Location	- City or To	wn, State
		4 Donation 5 DC	Other (Speci.	y)	Dul	aney V	alley Me	em. Gar	rdens	11/29	/97 Time	onium	, Mary
auce	1	21. Signature of Financial	Service/Lice	1000	110		2. Name and Add						
8					1 1		uda-Rucl	k Filner	ral H	ome of	Dundal	k. In	G .
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Day November 11:10 am COOLEY 28 1997 4a. Facility Nama (If not Institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Death CARROLL AIRHAVEN SYKES VILLE, MO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) Deys 1 M 22+F Yrs. 96 Oct 19, 1901 Maryland 213-40-0784 Usual Residence of Decedent 10d. Insida City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Sykesville Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21784 7200 3rd Avenue 12. Wes Dacedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Rece - Amarlcan Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Give 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Teacher Garrison Junior H.S. 4 years 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) E. Meyer Thomas W. Shutt Mary 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2706 Alden Road Baltimore, MD Mrs. Alice Luken 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Ramovei from Stete 4 ☐ Donation 5 ☐ Other (Specify) 12/2 Havre de Grace Rock Run Cemetery 22. Nema and Address of Fecility Loring Byers Funeral Directors, Inc. uns 8728 Liberty Road Randallstown, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, about or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disaase or condition resulting in death) Aspiration hours Due to (or as a consequence of) 1 year Diabetic betic gastroporesis Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disease or injury that inhieted events resulting in deeth) Lest 10 years Dia betes Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

8

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f shor the Medical Examiner must be notified at

should be Ind Mental

Pages 1 and 2 Department of Health Important: If Nem 27 Directo

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Examiner Physician/Medical þ

requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760 of Vital Records, certificate has Division

Completed 5 Certification:

edical

he Hospital or Attending Physician: The in 24 hours after death.

The Funeral Director: After this certificat pletely filled in by the funeral director, p. To the within 2 vith of To the F

Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. Diabetes 25. Wes case referred to medical 26. Place of Deeth (Check only ona) Hospitel; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28d. Describe how injury occurred 5 Pending investigation 1 Billeturel 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

29b. Signatura and title of certifler

0 1 1997

29c. Licensa number D34849

29d. Data signed (Month, Day, Year) November 28, 1997

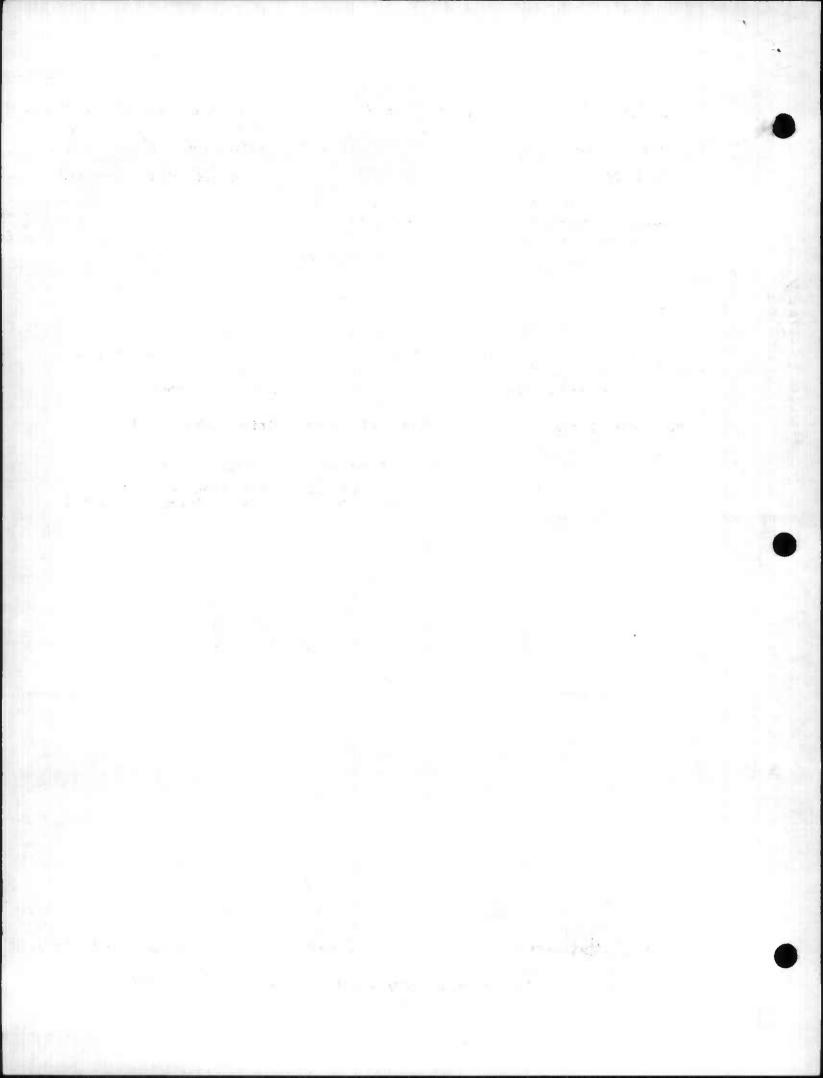
30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

MD 1646 Liberty Road & Hersburg MD 21784 31. Dete filed (Month, Day, Year)

State Registrar

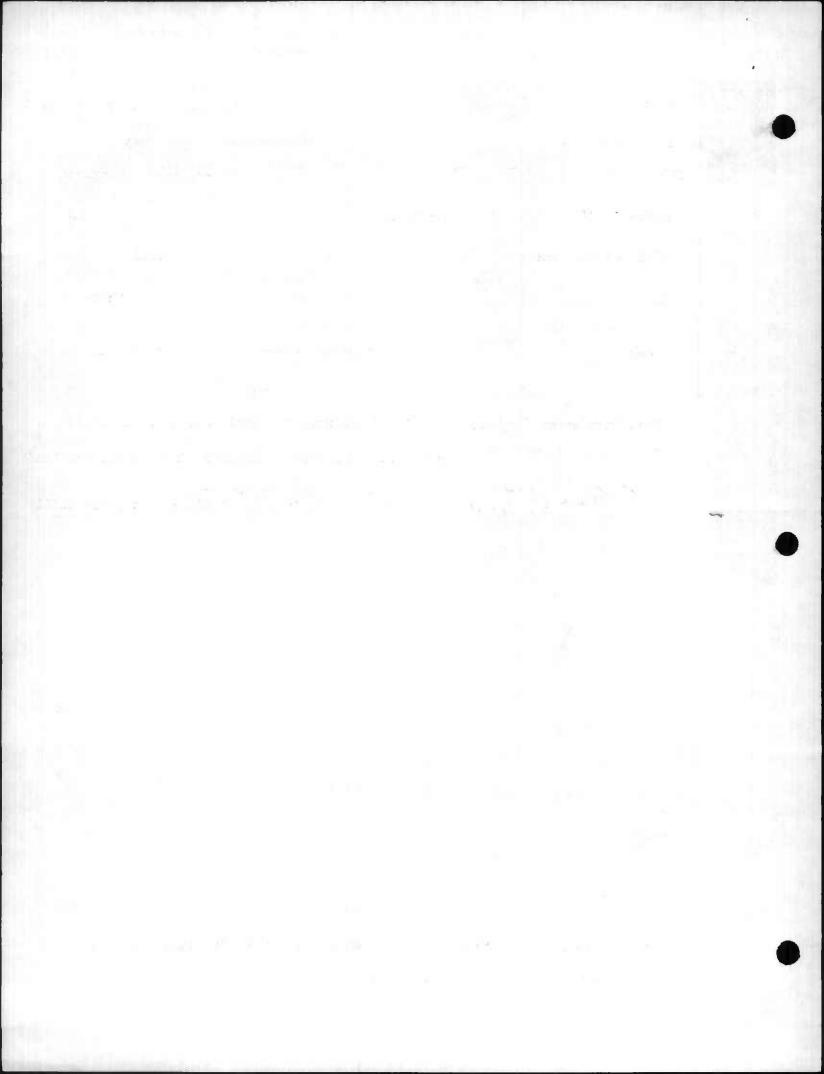
32. Registrars Signature

June Davidson Randelle



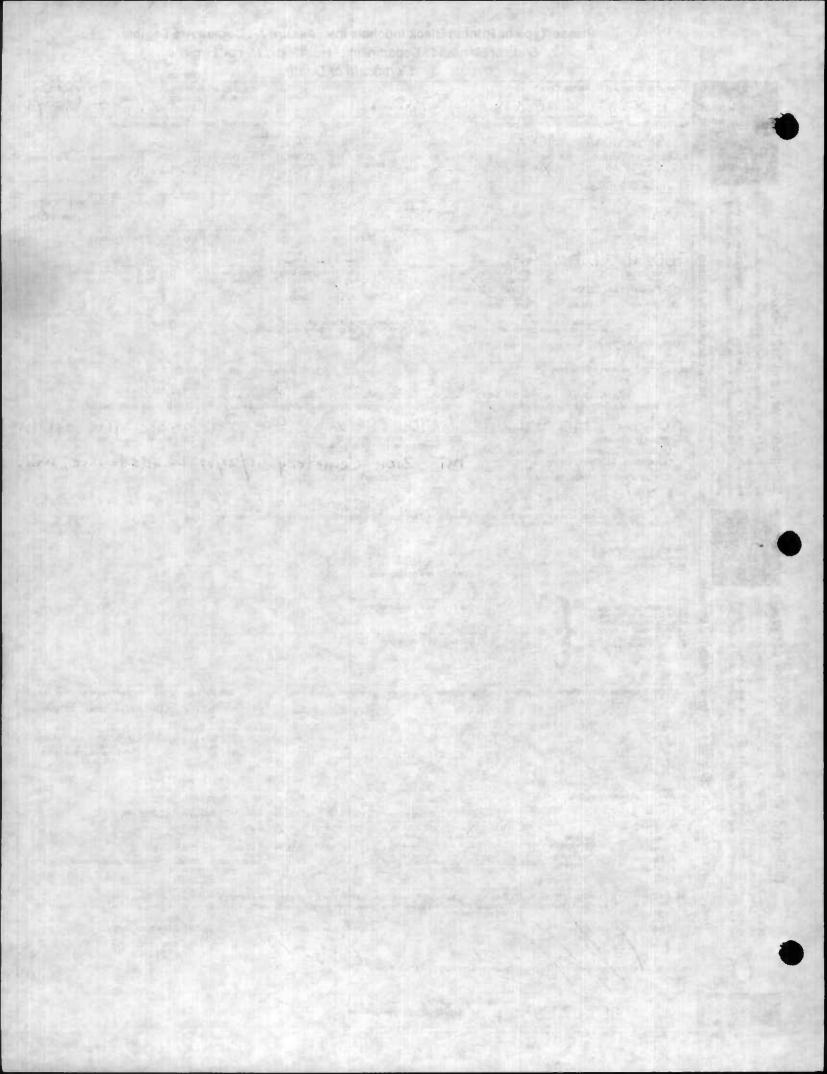
State of Maryland / Department of Health and Mental Hygiene 7

				Ce	ertificate of	Death			Reg. No.				
Physi /Med		1. Decedant's Nema (First, Middla, La Estelle	(arroll					2. Data of Dec Month	Day	Yaar 1997	3. Time of Deeth 6:19 PN		
Exam		4a. Facility Name (If not Institution, git Sinai Hospital					wn, or Lo	ocation of Deeth		of Deeth			
Funera Directo		5. Social Sacurity Number 6. 5		yrs. last birthday, Yrs.	Months Day	r If Under		8. Date of Birt (Month, Da Aug 15	h	9. Birthp	lece (Stata or Foraign try) yland		
Maryland H show	tor	10a. Stata 10b. County Maryland N/A	100	Baltimo						1	0d. Insida City Limits 1XX es 2 ☐ No		
r 28a-f	Director	10e. Street and Number			10f. Zip Coda				10g. Citizan of	0g. Citizan of What Country?			
h witi		2095 Rockrose A	venue		2.1	1211			U.S.	A			
5-UUZU 72 hours after death with the Maryland natural, or items 23s or 28s-1 show pleat Examinet must be notified at	by Funeral	11. Marital Status 1 Navar Married 2 Married Widowed 4 Divorced	Was Decedant of If Yas, specify Cu		igin? (Spa n, Puarto	acify Yas or No- Rican, etc.)		ce - Americ ck, Whita, v: Whi					
72 hours	ted	15. Decedent's E	Yaar or Datas:	16a. Dece	edant's Usual Occi	upetion			16b. Kind of B	usinass/Inc	dustry		
within 7 with 7 han "n	Completed	(Specify only highast grant Elamantary/Secondary (0-12)	College (1-4or 5+)	life.	skind of work don DO NOT usa ratii	a during mos ed)	t of worki	ing					
nd 2127 e filed within al Hygiene. other then "	Sol	unk			Factor	y Worl			Westi		se Co		
Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exam	To Be	17. Fathar's Nama (First, Middla, Last	unk			18. Mothe	er's Name unk		Maiden Surnar	na)			
Aar 2 sh and is m		19a. Informant's Name/Ralationship			ing Addrass (Stree								
s 1 and 1 Health tem 27 other tr		Alfred Cianferan			Paine S		, Bal			-			
Pages ent of nt: If it		20a. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Spacial			osition (Name of Imatory or other pi Ldge Ceme		12	Data 2/2/97	Pikesv		Maryland		
Baltim permit. Pa Departmen important: any injury		21. Signetura of Funaral Service Licensaa 22. Name end Addrass of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Marylan											
Physician /Medica Examine		23a. Part1. Entar the disaasa, or com shock, or haart failura. List only Immediata Causa (Final disaasa or condition rasulting in daath)	a. Sepsis	daath. Do not an	itar tha moda of dy	ring, such as	cerdiac d	or raspiratory ar	rast,		Approximata intarval Batween Onsat end Death		
BOX 56750, seth certificate be axecuted attending physician and for use as the burial-transit	n/Medicai Examiner	Sequantially list conditions, if any, laading to immediata ceusa. Enter Undarlying Cause (Disaasa or Injury that initiatad avants rasulting in deeth) Lest	c	to (or as a consector (or es a consec	· zeroci								
. 0 00	Physician	Part II. Other eignificant conditions of	contributing to death but not	rasulting in tha u	undarlying ceusa g	jivan in Part i		23b. Dld t	obecco use co	ntribute to	the ceuee of death?		
T tal of the contract of the c	by Ph							101	res 2□ No	3 Prot	pably 4 Unknown		
aw requir sa been s 2 should	Completed								en autopsy rmed?	ave	ara autopsy findings ellebla prior to mplation of ceusa death?		
The Head	Con							101	as 25 No	1 [Yas 200		
clan: entillo sotor,	Be	25. Was cesa rafarrad to madicel axaminar?					of Daath	(Check only o	na)				
Of VIE Physician: this cariffic ral director,	J.	1≱Yas 2□ No	The second secon	2 ER/Outpatie	nt 3LI DOA				lance 8 Oth		1)		
Attending P or death. ector: Aller by the funer	Certification:	27. Mannar of Deeth 1. Natural 5 ☐ Panding 2 ☐ Accidant invastigatio 3 ☐ Suicide 6 ☐ Could not be		28b. Tima o tnjury	W	uryat ork?]Yas 2□		28d. Dascribe I	now injury occur	red			
palator Attendours attendours attended:		4 Homicide datamined	28e. Place of Injury - / building, atc. (Sp	At homa, farm, st	raat, factory, office	a .	1	28f. Location (5 City or Тои		er or Rura	l Routa Number,		
Azz s	edicai	29a. Cartifiar (Check only one) 12 CertifyIng Ph	yelclen: To tha bast of my niner: On tha basis of axan and mannar statad.	knowladga, daat nination and/or In	th occurred at the avastigation, in my	tlma, data an opinion, daa	d place, a th occurre	and dua to tha ded at tha tima,	causa(s) and madata and place,	annar as st and dua to	ated. tha causa(s)		
To the within 3 To the comple	M	29b. Signature and title of certifler	_ MD			sa numbar 4023	ale _D		29d. Data signe		Day, Year) .6 1997		
		30. Nama and addrass of person who Erik Delue	complated ceusa of death	(Itam 23a) (Type,									
Si Regis	ate	31. Date filed (Month, Pay, Year) DEC 0 1 1997	32. Registrar's S	Itam 23a) (Type, Hospit Ignature Son-Randa	œ								



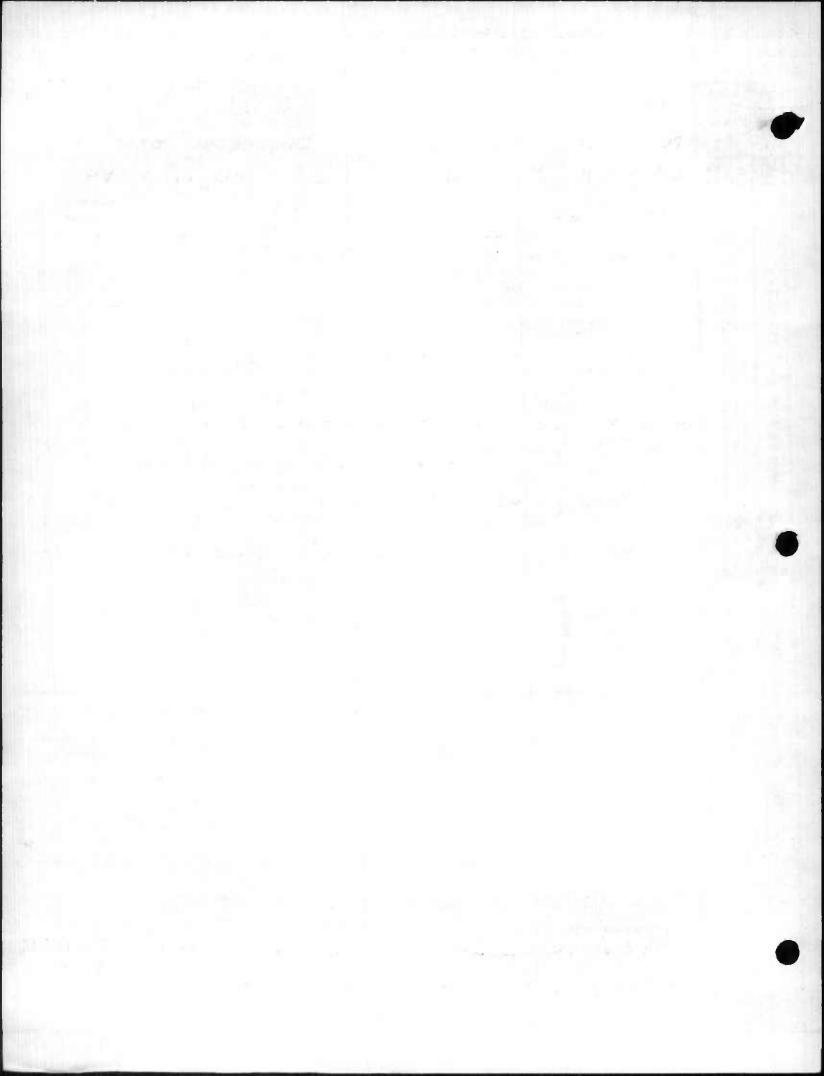
State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		Reg. No.	7 35020
Physic /Medi		1. Decedent's Name (First, Middle, Last) Robert Patrick Dunn	2. Dete of D Month	Day 20	Year 33 Time of Death
Examir		4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Li	ocation of Dee	eth 4c. County	of Death
Funeral Director		5. Social Security Number 6. Sex 12 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Dete of B	oay, Year	9. Birthplace (State or Foreign Country)
Maryland -f show	tor	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location BOLL 1770P			10d. Inside City Llmits 1 ☐ Yes 2 No
with the M a or 28a-f	Direc	10e. Street end Number		10g. Citizen of V	Vhat Country?
ter death items 23	by Funeral Director	11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, specify Cuben, Mexicen, Puerto 1 Yes, Sive 1 Yes, Sive 1 Yes 2 No Specify:	ecify Yes or N Rican, etc.)	lo- 14. Rac Blac Specify	e - Americen Indian, ck, White, etc.
2121 I within iene. Than	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+)	ing	16b. Kind of Bu	usiness/Industry
yland build be file Mental Hy mrked othe	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name Che	nille	Beny	ra Hanna
more, ages 1 an ent of Heel M: If Rem 2 ry or other		198. Informant's Name/Relationship (Type, Print) RODIN HOND 20a. Method of Disposition Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify)	Date	11: more	Md 2016 City or Town, State
Balti permit. I Departm Importar any Injur		21. Signature of Funeral Service Licensee 22. Name and Address of Feching 30 allie Housell Jr. 108 W. Hort	h Au	re Ba	H. Md 2120,
Physician /Medical Examiner		23e. Part1. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	or respiratory	ariosi,	Interval Between Onset and Death
8 / 50, ete be executed hysician end the burishransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):			
O tillio	Medical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
hat the death of by the atter detached for a	Physician/R	Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	3 10	tobecco use co	ntribute to the cause of death
necords, F.C. he law requires that the de e has been signed by the signe 2 should be detached	Completed by		24a. Wa	s an eutopsy formed?	24b. Were autopsy findings aveilable prior to completion of ceuse of death?
VITAL Sician: Ti certificat irector, pa	To Be Corr	25. Was cese referred to medical examiner? 1 Yes 2 No	h (Check only	Yes 2 No	1 Yes 2 No
DIVISION OF To the Hospital or Attending Phys within 24 hours elter death. To the Funeral Director: After this completely filled in by the funeral director.	Certification: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury et Work? 2 Accident investigation (Month, Day Year) M 1 1 Year 2 No.	28d. Describe	how injury occur	
Hospital of 24 hours els Funeral D	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	end due to the	e cause(s) and ma	inner as stated. and due to the cause(s)
To the within To the comple	Me	290. Signature and little of certifier 29c. License number D26/146		29d. Date signer	d (Month, Dey, Year)
Sta		30. Name and address of purion who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrar's Signature			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Y5 HODGES ST. DYSON NUUCMBIN 25 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner HOSPITAL BACTIMORE WEST WEST SACTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** 10M 20 F Months Days Yrs 218-10-7640 Director 1004 Usual Residence of Decedant death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic avent, its feaces Examiner mad be notified as Md NA Baltimore 1 Nos 2 No Director 10e. Straat and Number 10f. Zip Code 10g. Citizan of What Country? BRIGHTON STREET USA 3111 21216 12. Was Dacedent Ever in U.S.
Armed Forces?
1 Series 2 No 3 No 15 Yes, Give
Yaar or Dates: 1 19 14 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□M6 Blac by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Dacedent's Education (Specify only highest grada completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) FFICE 12+h YOSTAL CARRIER 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be JEORGE DUZON EDNA WUNN 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Mary T. Lyson-Wife Dalto. Hd. 21216 BRIGHTON ST. 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Foe. Ver. Con. 12-2-97 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility March la 4300 Wabash Are Batto. 21215 Warne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arreat, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final De UTE MOCKADINE INFACTION disease or condition resulting in death) Examiner Dua to (or as a consequence of): physician and s the burial-trans Sequantially list conditions, if any, laading to immediate ceuse. Entar Underlying Causa (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Dua to (or as a consequance of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? s been signed by t should be detach TETVes 2 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 2 LANO 1 Yes 2 No Division of Vital 25. Was casa referred to medicei 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 10 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred of or Attending P safter death.

I Director: After t Certification: 28a. Data of Injury (Month, Dey Yaer) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicida To the Hospital or within 24 hours aff To the Funeral Di completely filled is 1 Cartifying Phyaician: To the best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) NUMBIR 25 1997 BAHORUSTU 30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print) OLD (OURT NO) NCCHACL BEKREWAN NO NO 31. Date filed (Month, Day, Yeer) 32 Registraria Signature Www. Davidson-Gandelle State 0 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35938 Certificate of Death 1. Decedent's Neme (First Middle Leet 2. Dete of Deeth Month **Physician** DOLAN ONALd 300 Trick NOU /Medical Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner squater Wharf. If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 10 M 2 F Months 59 Director 376-36-1756 Wisconsin August 19 1938 Usuel Residence of Deceden 10a. State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Edgewater 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1019 Carrs Wharf Road 21037 U.S.A. 12. Was Dacedenf Evar In U,S. Armed Forcas? 12(1)Yes 2 | No If Yes, Giva Yaar or Detes: Was Decadent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Reca - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Research Medical 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Orville Dolan Mary Hannah Gallagher 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Lou Masters/ Ex-Wife 9908 Betteker Lane, Potomac, MD 20b. Plece of Disposition (Neme of cemetery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 □ Burlel 2XI Cremefion 3 □ Removel from State Metro Crematory 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Lio 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Deeth **Physician** tmmediete Ceuse (Finet diseese or condition resulting in death) /Medical EXSANGUINATION UNK Examiner AStrointestINA Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseesa or Injury thef initiated events resulting in death) Lest Due to (or es e consequance of): Physician/Medicai Dua to (or es e consequença of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Arteriosclerotic Heart þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed D138 A5 8 1 Yes 25KNo 25. Wes case raferred to medical Be 26. Pleca of Deeth (Check only one) exeminer? 2 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. fnjury et Work? Certification: Neturel 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be detarmined 3 Suicide 28a. Place of Injury - Af homa, farm, sfreef, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

Box 68760 P.O. Records, of Vital Division Attending

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death

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Baltimore, Maryland 21215-0020

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

the attending ž ď page 2 cuntific 着 Attor death. after death Director. Funeral Medical To the T

> State Registrar

31. Dete filed (Month, Day,

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(Check only one)

29b. Signature end title of cartified

0 1 1997

29a. Certifier

Deputy

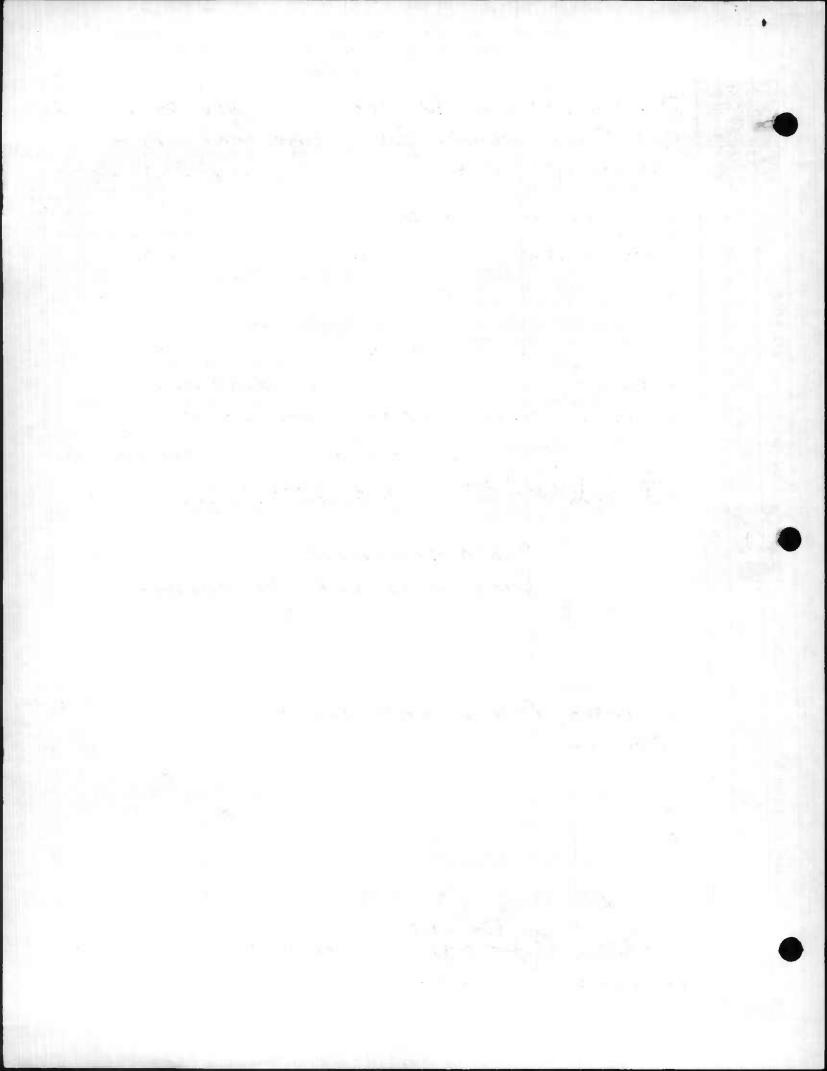
1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dafa signad (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23e) (Type, Print) 1. Iliam OK

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ONTS, MD
32. Registrer's Signeture w Davidson-Randell



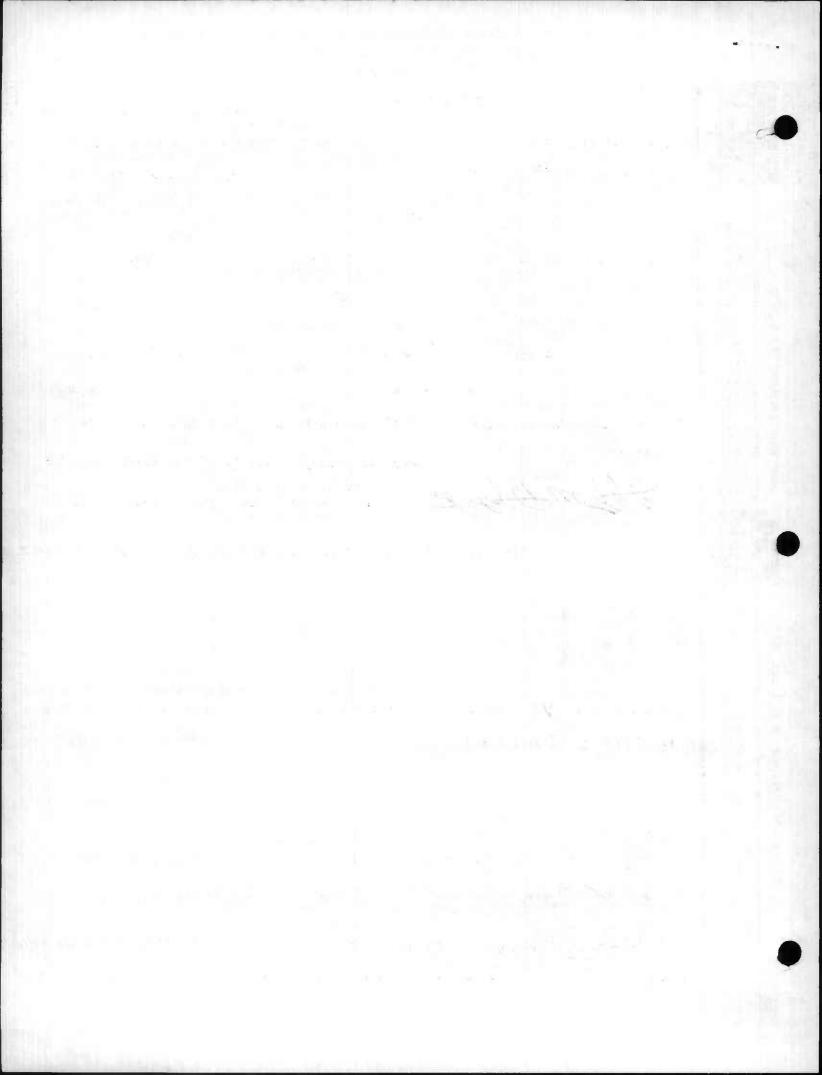
State of Maryland / Department of Health and Mental Hygiene 7 35939

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State of Maryland / Department of Health and Mental Hygiene 7 250

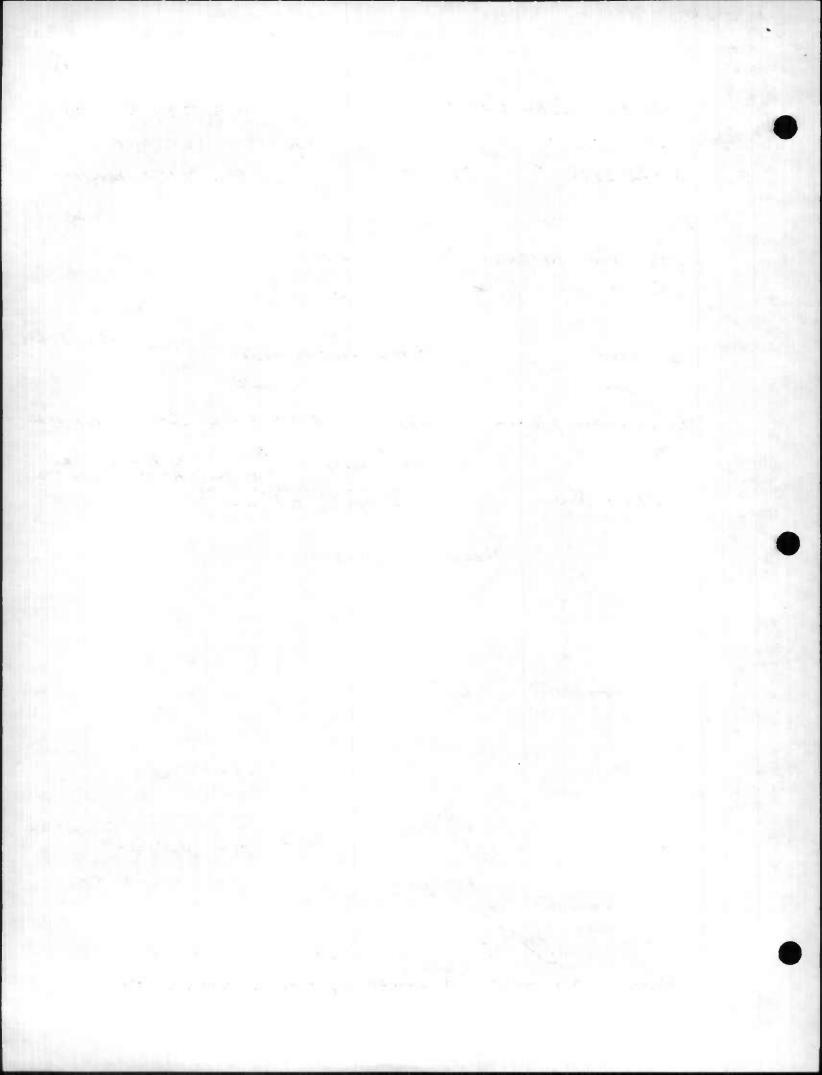
EVANS				Certif	icate of	Death	Re	g. No.	33	940
Physic		1. Decedent's Neme (First, Middle, Last Warken Jo					2. Dete of Deeth Month NOVEMBER	Dey	Year	3. Time of Death
/Med Exami		4e. Fecility Neme (If not institution, give				4b. City, Town, or		4c. County).UI F
		SINAI HOSPITAL E	R			BALTIMOR	Œ	1	1/12	
Funeral Director	_	5. Sociel Security Number 6. Se 0 - 72 - 3778 Usuel Residence of Decedent	7. Age (In yrs.		Under 1 Yeer onths Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, May	Year) 958	9. Birthplace Country Nary	ce (Stete or Foreign
how		10a. Stete 10b. County	10c. Cit	y, Town or Locati					10d	. Inside City Limits
Ba-1 s	Director	Marylons N/h		Baltin	HEVE					1Dres 2□No
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death oms 23	Funeral	11. Merital Stetus	12. Wes Decedent Ever in U	S. 13. Wes		dispenic Origin? (S en, Mexican, Puert	pecify Yes or No-		e - American	Indian,
15-0020 72 hours after death with the Maryland "natural", or items 23s or 28s-f show solical Exercises must be notified at	by	Never Merried 2 Marrlad 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2- No If Yes, Give Yeer or Dates:		Yes 2 No		o Rican, etc.)	Specify	k, White, etc	
72 hou	eted	15. Decedant's Edu (Specify only highest grad	cetion e completed)	16e. Decedent	's Usual Occup	petion during most of world)		6b. Kind of Bu	siness/indus	stry
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and libe fill nital H ed oth	Be	17. Fether's Neme (First, Middle, Last)					ne (First, Middle, M	leiden Sumam	e)	
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Malth er trau		LINDA JONES /3	GiERO							2d 21211
Baltimore, Maryland semit. Pages 1 end 2 should be filed Department of Health end Mental Hyg important: If item 27 is merked other any lojury or other traumatic event, place.		20e. Method of Disposition		leca of Disposition	on (Neme of any or other ple	ce)	Dete 2	Oc. Location -	City or Town	, Stete
Baltir permit. P Departme Importan any Injur		4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licens		22. Na	(Neme of Dete 20c I	HAM	5 Line	Wat Home		
Depa Impo		Jens offer		504	HOREI.	5761541NN	LG AUS			
Physician /Medical Examiner	ner	Immediate Cause (Final disease or complete, or heart feilure. List only or limited the control of the control o	Itead	F T	vies	ng, such es cardiad	c or respiratory arre	St,	fr	pproximeta iterval Between inset end Deeth
The state of	Examiner	Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceusa (Disease or injury	Due to (o	r es e consequen	ce of):					
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requires that the deam requires that the deam een signed by the atten-	y Physician/	Pert II. Other significant conditions con	infouring to death but not rast	utting in the under	lying ceuse giv	van in Part t.	1 \(\text{Ye}	here.		ne cause of death?
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_ F # & &	Con						1 ☐ Yes	2 2 No	1 🗆 Y	fes 2□ No
f Vital ysician: Th is certificate director, pag	Be	25. Wes cese referred to medicel examiner?	lospitel:		l Out		eth (Check only one)		
of Vita Physician: this certific	: To	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Oth	4 LI Nursing H	ome 5 Resider			0840
Division of or Attending Physeler death Director: After this in by the funeral di	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Year)	Injury (7/0		k? Yes 2. PNo		colls	ルへ	
DIVISION Attended by Director: ed in by the	Certif	4 Homicida determined	28e. Place of Injury - At he building, etc. (Specify	l was	fectory, office		28f. Location (Str. City or Town,	Stete)		V.
DIVI To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edical (sician: To the bast of my knowner: On the basis of axaminer end mannar stated.	wladge, death occ			, end due to the ce	use(s) and me	nnar as state	ed.
To the within To the	Me	29b. Signeture end title of certifier	01/1		29c. Licens	e number	29	d. Date signed	d (Month, De	y, Year)
		1	1 32		OCM	E	NC	VEMBER	23, 19	197

State Registrar

Davill 31. Dete filed (Month, Day, Yeer)

30. Name end eddrass of person who completed cause of death (Itam 23a) (Type, Print)

Forler 111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth ELLIS LILLIAN 1800 Nov 4a. Fecllity Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore City If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. lest birthdey) Birthplece (State or Foreign Country) Deys 1 □ M 2 🖾 F Yrs. 80 Jan 8, 1917 258-16-2855 Georgia Usuel Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yas 2 No Maryland Baltimore Randallstown 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 9201 Bengal Rd. 21133 USA 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Giva Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Ledford M. Hughes Stella Dodd 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9201 Bengal Rd. Catherine Scheuch (Daughter) Randallstown, MD 21133 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) Lake View Memorial Park 11-29 Sykesville, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Loring Byers Funeral Directors, Inc. 23a. Perf. Entar the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, Approximately 10 and 21133 Approximete Intarval Between Onset and Deeth INFARCTION Immediate Cause (Final HRS MYOCARDIAL disease or condition resulting in deeth) Due to (or es e consequence of): Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown RESPIRATORY FAILURE,

Physiclan /Medicai Examiner

nding physician and use as the bunel-transit

Physician/Medical

Completed

Be

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

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Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

the Maryland

death with

filed within 72 hours after

permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If flem 27 is marked other than any injury or other trainment.

Saltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last

31. Date filed (Month, Day, Yeer)

DEC 0 1 1997

LUNG TUMOR

24b. Were eutopsy findings avelleble prior to 24a. Wes an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yes 2000

25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of

27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. tnjury et Work? Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident

3 Suicide 6 Could not be determined 28I. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, lectory, offica building, etc. (Specify) 4 Homicide

Certification: 1 Exertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end manner as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner stated. 29a, Certifier 29b. Signatura and titla of certifier

Masslew Uslobrez us

29d. Data signed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of deeth (Ieo 23a) (Type, Print) MATTHEW MCNABNEN 2434

W. BELVEDERE BAY, NO INIS

State Registrar

After

if or Attending after death. Director: Aft

hours

307 for the "107"

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) MARY ELIZABETH FARINA November 24 03004 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE GILCHRIST CENTER If Under 1 Year If Under 24 Hrs. 8. Dale of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (Steta or Foreign Months Days Hours 1 ☐ M 2 🕶 F 95 Yrs. FEBRUARY 3 1902 052-18-5412 NEW YORK Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits MARYLAND BALTIMORE COCKEYSVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 SHERWOOD ROAD 21030 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Giva Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Naver Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 N Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 6 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) (UNKNOWN) **JAKUBEK** ELIZABETH (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) COCKEYSVILLE, MD 21030 219 SHERWOOD ROAD ELIZABETH K. RUTHER/DAUGHTER 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cramation 3 KRamoval from State LOCUST HILL CEMETERY 11-25-97 DOVER. NEW JERSEY 4 Donation 5 Other (Specify) 21. Signature of Funaral Servica Licenses 22. Name and Address of Facility MITCHELL-WIEDEFELD HOME 6500 YORK ROAD BALTIMO Leve BALTIMORE, MARYLAND 21212 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Ceuse (Finel disease or condition resulting in death) dementin end. Stage month Due to (or as a consequence of) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown neumo coccal pneumonia 24b. Were eutopsy findings available prior to 24e. Was en autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospite 1□ Yes 2No 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work?

1 Tyes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) and manner es steted.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated.

N. Charles

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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P

1 Natural

3 Suicida

29e. Certifier (Check only one)

2 ☐ Accident

4 Homicide

5 Pending investigation

6 Could not be determined

Certification:

edical

permit. Pages 1 and 2 Department of Health et Important: If item 27 la any injury or other trac

Pages 1

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or flems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

Il Hygiene. other than "natural",

2 should be filed within 72 Pend Mental Hygiene.

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attending physician and of for use es the bunal-trans signed by 8

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Division of Vital

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Riley 31. Date filed (Month, Dey, Yeer)

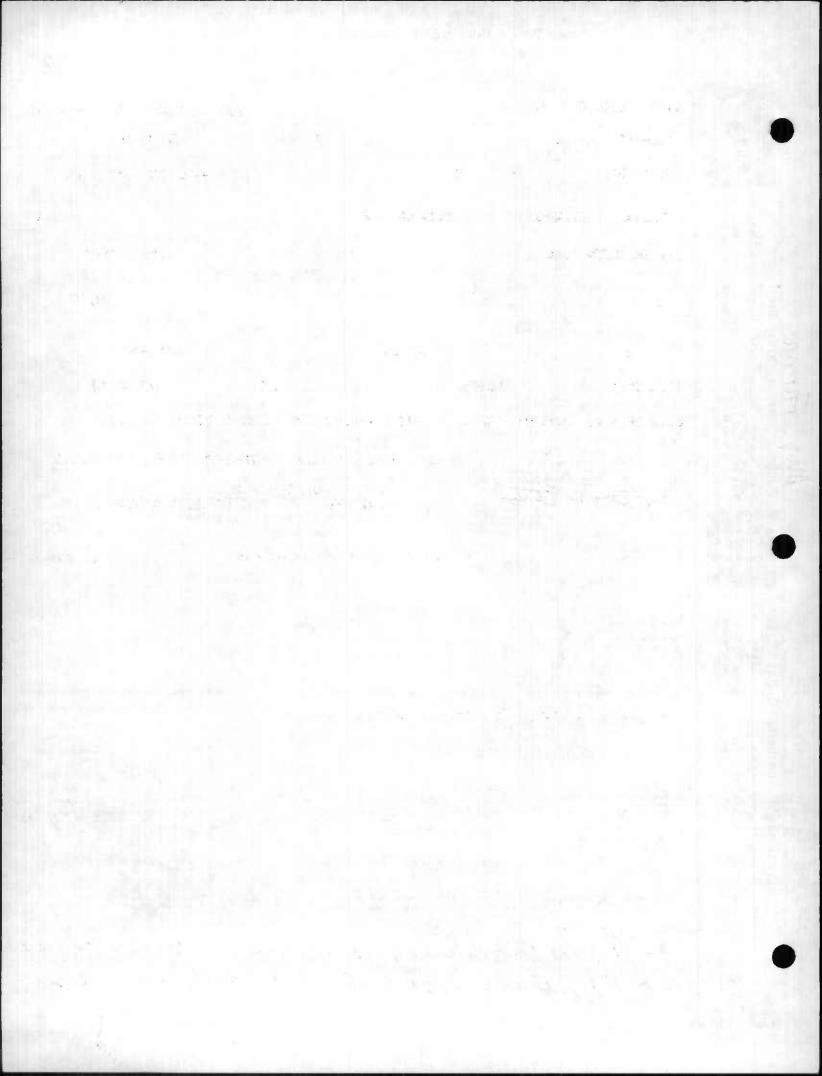
29b. Signature and 100 of certify

GBME 32. Registrar's Signature Madow-

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

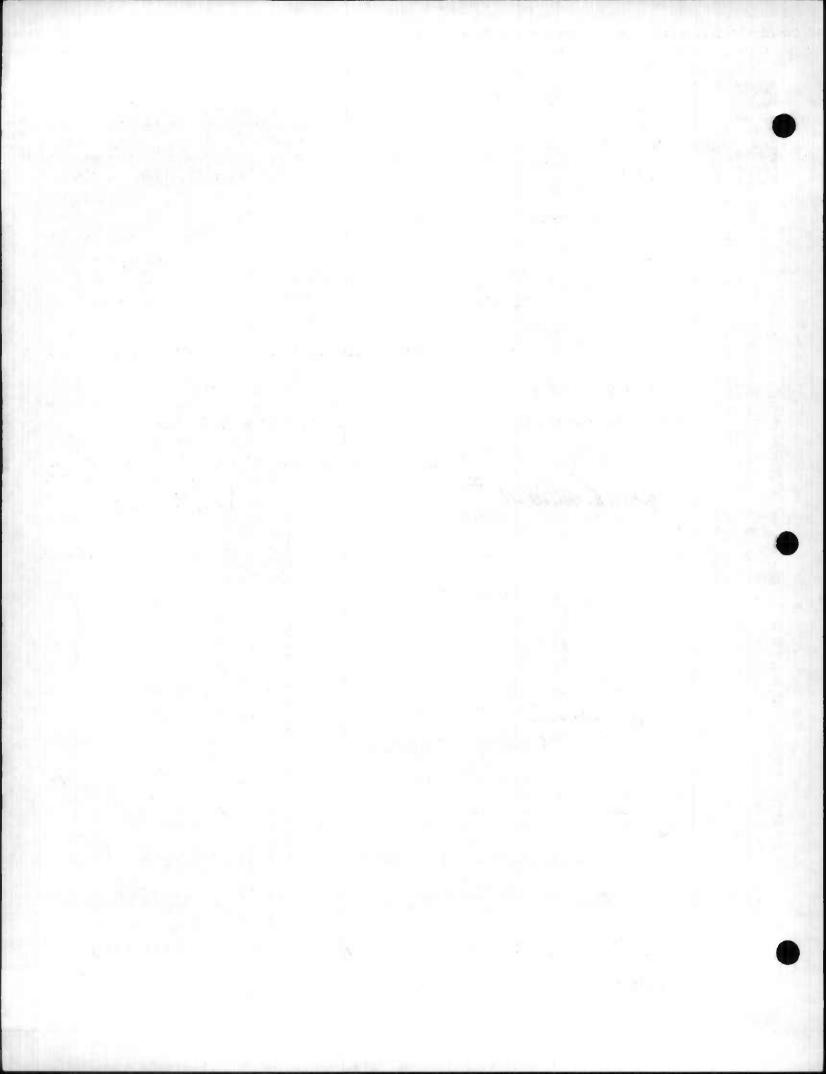
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 5 9 4 3

		Decedent's Neme (First, Middle, L	ast)		Cel	uncale	e Of	Death	2. Dete of De	Reg. No.		3. Time	of Death
Physicia		Arthur George F							November 26, 1997			2:30	
/Medica Examine		4a. Fecility Neme (If not institution, gi		er)				4b. City, Town, or I		-	y of Deeth		FFI
LAGIIIIIC	"	205 E. Joppa Rd						Towson		Balt			
Funeral Director		5. Social Security Number 6.	the same of the sa		last birthday) O Yrs.	If Under Months	1 Yeer Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	th	9. Birth		e or Foreign
* w		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation			-			10d. Inside	City Limits
Hed	io	Maryland Baltime	ore	To	owson		1 ☐ Yee 2 💢					e 2 No	
or 28	Se le	10e. Street end Number	- A.L.			10f. Zip	Code			10g. Citizen of	Whet Cou	intry?	
23a	<u>a</u>	205 E. Joppa Rd.				21	286			United	State	es	
hatten Examiner must be nettind at	by Funeral Director	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decede Armed Force 1 12 Yes 2 If Yes, Give Yeer or Dete	es? □ No		Ves Decede Yes, speci Yes 2		Ilspanic Origin? (S en, Mexicen, Puert Specify:	pecify Yes or No o Ricen, etc.)	Special	ck, White,		
leal	g g	15. Decedent's E	ducation	***************************************	16e Deced	ent's Usue	Occup	petion		16b. Kind ot E			
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Tue C	Be C	17. Father's Nama (First, Middla, Las	1)					18. Mother's Ner		110.00	орестатите		
tion in	ToB	Arthur George For	cni					Alice B	McDonr	nell			
aumatic event, the M		19e. tntormant's Name/Raletionship	(Type, Print)		19b. Meilin	g Addrass	(Street	and Number or Ru	ral Route Numb	er, City or Town	, State, Zij	p Coda)	
n 27 ler tr		Mildred L. Forni	/wife			. Jop			vson, M				
nny injury or other traumatic event, the Monee.		20a. Method of Disposition 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		110	Plece of Disposemetery, crem				Dete	20c. Location			and
any inju		21. Signature of Funerel Service Lice	d Addre	ess of Fecility Mi.1 650	Gard. 11/29/97 Timonium, Maryland Fedility Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212								
	Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b. Cov	Due to (d	or es e consequence es	uence ot):					-		
	ician/M	Pert II. Other significent conditions	d.	h but not roo	ulting to the un	doubles se		ing la Dest t	225 014	tobacco use co		to the same	
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page 2	E								1 🗆	Yes 2000	1	☐Yes 2	ZHO
	90	25. Was cese rafarred to medicel examinar?						26. Plece of Dee	th (Check only	one)			
	9	1 ☐ Yes 25 No	Hospitel: 1 Inpe		ER/Outpetien			4 LI Nursing H	ome 5 Resi	dence 6 □Ot	her (Speci	fy)	
completely filled in by the funeral	Certification:	27. Mannar of Deeth Mannar of Deeth Solitative Solitative Solitative		njury De <i>y Year)</i>	28b. Time of Injury	М 28	Bc. tnjut Wot	yat nk? Yas 2⊡No	28d. Describe	how Injury occu	rred		
al Direction by	Certi	3 ☐ Suicide 6 ☐ Could not to detarmined	289. Place of	Injury - At he etc. (Spacif	ome, ferm, stre	eet, tectory,	y, office 28t. Location (Street and Number or Rural Route Number City or Town, Stete)					m <i>ber</i> ,	
To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only one) 1 Cartifying Pl	nysictan: To the be miner: On the basis and menner	of examina	wledga, daath tion end/or inv	occurred e estigation,	t the tir	na, data and plece pinion, deeth occu	, end due to the rred et tha time,	ceuse(s) and m date end plece,	anner as s end due t	steted. to the cause	e(s)
To the Funeral completely filled	E	29b. Signeture end title of certifier				29c.	Licens	e number		29d. Deta signa	ad (Month,	Dey, Year)	
		20 Name	1	Maria iii	00-1/7		0:	32743		111	266	フ	
0		30. Name and address of person who	THOMK		n 23e) (Type, I	rint)							
State	e	31. Data tilad (Month, Day, Year)		strar's Signa	iture								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth NOVEMBER 22, 1997 **Physician** DANIEL FOWLER 4:40 PM /Medical 4e. Fecility Neme (If not institution, give street end number)
Saint Joseph Medical Center 4b. City, Town, or Location of Deeth 4c. County of Deeth
Baltimore **Examiner** If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1₽M 2□F 219-32-7512 62 Yrs Director MARYLAND Usual Residence of Decedent the Marylend 10e. Stete 10b. Count 10c. City, Town or Location must be notified at 10d. Inside City Limits 1 Yes 2 □ No Director MARYLAND N/A BALTIMORE CITY 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 5009 ALHAMBRA AVENUE items 23a 21212 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. traumatic event, the Medical Examiner 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 6 Baltimore, Maryland 21215-0020 Specify: NEGRO 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry illed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) BTH STOCKPERSON BAR other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) s 1 end 2 should be fil I Heelth end Mental H tem 27 Is marked oth Be DANIEL FOWLER , SR. LUTENE MC CARTHY 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2:
Department of Heelth er
Important: If Item 27 Is
any injury or other trau BERNADINE TALLEY / 2311 MONTICELLA sister ROAD BALTIMORE, MD. 21216 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from Stete
4 Donetion 5 Other (Specify) VOSHELL CEMETERY NOVEMBER 29, 1997 BALTO.CO, MD. 21. Signifure of Funeral Service Licenses 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME lern 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Pert1. Enter the disease, or complications thet aured the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** RESPIRATORY FAILURE Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE be executed physician and s the burial-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es e consequence of): that the death certificate 980 Pert fl. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should be det Records, by 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? 24e. Was en eutopsy performed? Completed page 1 ☐ Yes 2 ☑ No certificate Division of Vital 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After or Attending 1 Naturel 5 Pending deeth. 1 Yes 2 No Investigation 2 Accident Director 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Medical 29a, Certifier 1 🗓 Certifying Physicfen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. 2 Medicel Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 4 5 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D37254 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BOON P. LIM M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 31. Dete filed (Month, Dey, Year)

State Registrar 32. Registrar's Signature rila Dandson-Randola Control Superior Supe

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35945 Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death OVEMBER 24, 1997 PM mes 4a. Facility Nama (If not Institution, give street and number) 4b City, Town, or Location of Death 4c. County of Deat 3820 U 5. Social Security Number 7. Aga (In frs. last birthday) If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, If Undar 1 Yaar 6. Sax S. Birthplaca (Stata or Foreign Country) Months 12M 2DF Days 212-26-588 Usual Rasidance of Dacedant -26-5886 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 WYas 2 □ No more 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 0 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U.S. Amed Forcas? 1 Yas 2 No If Yas, Giva 14. Race - American Indian, Black, World, atc. 11. Marital Status 1 ☐ Nayar Married 2 ☐ Married 1 Yas 2 Ho Specify: 3 Widowed 4 □ Divorced Year or Dates: MERICAN 16b. Kind of Businass/Industry 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) College (1-4or 5+) IVATE 18. Mothar's Nama (First, Middla, Malden Sumama) 17. Fathar's Nama (First, Middla, Last, helmai 1emings 19a. Informant's Name/Ralationship (Type, Print) (5/5/Er) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or m, State Lip Coda) 20b. Plece of Disposition (Numa of cematary crematory or pthar 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata □ Donation 5 □ Othar (Specify) iture of Funaral Sarvice Licensee 22. Nama and Address of Facility Home 1222 W. NorTh md.21216 23a ant 1. Enter the disasse, or complications that causad the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximata Intarval Between Onsat and Death Immediete Causa (Final disaasa or condition rasulting in deeth) 9 pratory Dua to (or as a consequance of): Carcinona 4009 Sequantially list conditions, if any, leading to immediata cause. Entar Undartying Causa (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 □ Probably 4 ☑ Unknown 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? 1 ☐ Yas 2 100 1 Yas 2 No

Physician /Medical Examiner

permit. Page Department of Important: If any injury or

DUC.

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Meryland neat of Health and Mental hygiene.
nnt: if flam 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Exeminer must be notified at

altimore, Maryland 21215-0020

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Examiner Physician/Medical 189 as ò P

iding physician and certificata be etter lew requires that the death been signed by the should be detached page 2 After this certificate has Attending Physician: the funeral director, death. after death Director: ŏ

Records,

Division of Vital

Completed Be 2 Certification:

25. Was casa rafarred to medical axaminar?

31. Data filed (Month, Day, Year)

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27. Mannar of Death

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3 Suicida

29a. Certiflar

4 D Homicide

filled in by To the Hospital o within 24 hours aft To the Funeral Di completely filled in Medicai

> State Registrar

29b. Signature/and title of contille

5 Panding invastigation

6 Could not be datamined

29c. License number

28c. Injury at Work?

1 ☐ Yas

2 No

26. Placa of Death (Check only ona)

Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Haspare

28d. Dascribe how Injury occurred

1 PCertifying Physician: To the best of my knowledga, death occurred at tha tima, data and piece, end dua to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and piece, and dua to the causa(s) and manner stated. 29d. Data signed (Month, Day, Year)

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28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

ad addrass of purion who complated cause of daath (Item 23a) (Type, Print) 30. Nama Daniel

Malsten

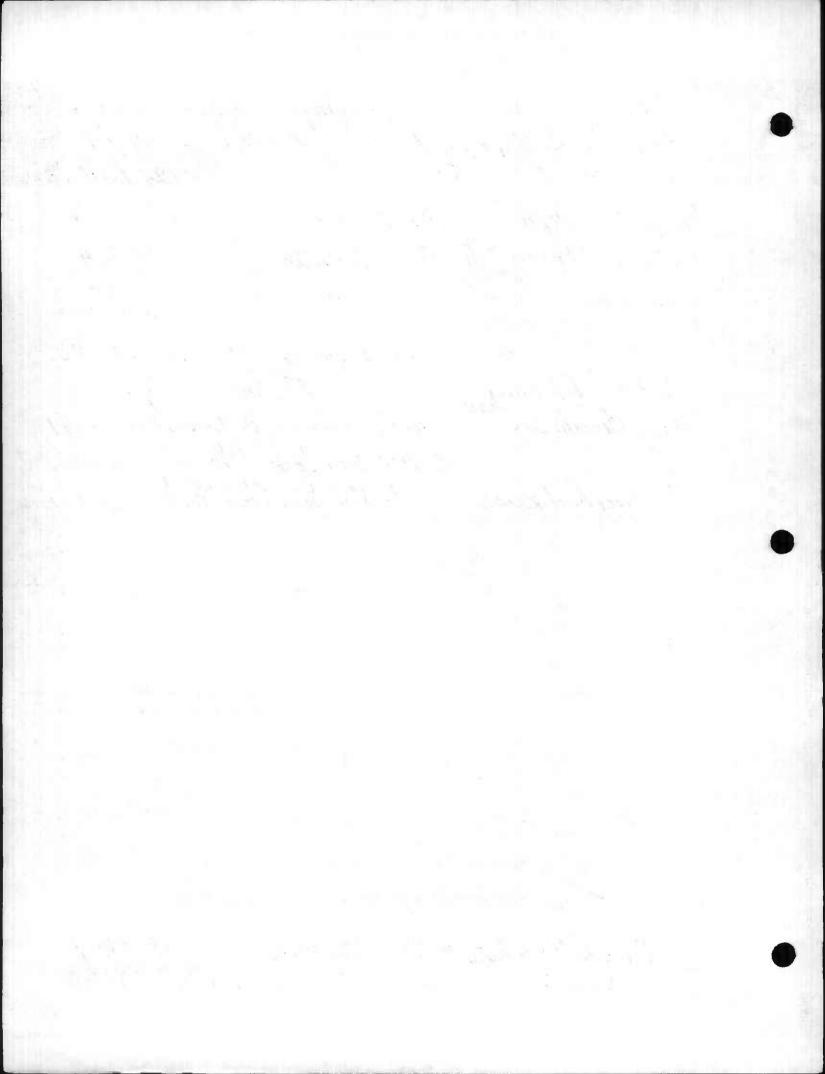
1 Inpatiant 2 ER/Outpatient 3 DOA

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28b. Tima of

Data of Injury (Month, Day Year)

32. Registrar's Signatura wh Davidson-Randall



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month HERBERT NOVEMBER 22,1947 TORD 3:50 PM 4a. Facility Neme (If not institution, give street end number) give street end number; NUC-51 NG CENTER PNDALL 3. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 4b. City, Town, or Location of Deeth 4c. County of Death PANDALLSTOWN OLD COURT BALTIMORE 5. Social Security Number 8. Dale of Birth (Month, Dey, Yeer) 9. Birthplace (State or Foreign 1912 BLACKSTONE 228-05-4585 JUN.10, Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No BALTIMORE MD na 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 ROAD 1819 COLMAR 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give A Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 ☐ Yes 2 ☐ Nox Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHEM STEEL LABORER 6 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) INDIA HAWKES LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Joyn, State, Zip Code) # 1819 COLMAR ROAD, BALTIMORE, MD # MELVINIA FORD WIFE 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Spriat 2 Cremation 3 Removal from State 4 Donelion 5 Other (Specify) WOODLAWN C EMETERY 11 - 29 - 97BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WM. C. MARCHF H.-4300 **AVENUE** Part 1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final MYOCARDIAL INFARCTION ~ 10 min disease or condition resulting in death) ELEBROVASCUL ACCIDENT Sequentielly list conditions, if any, leading to immediate cause. Enler Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MELLITUS, TYPE 2 24b. Were eulopsy findings evellable prior to completion of ceuse of death? 24e. Was an autopsy performed? 1 Yes 2 700 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. fnjury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 2 Accident

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Physician/Medical Completed Be 2

Certification: In by t

Director: After this certificate death.

Physician

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28a-f show must be notified at

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Pages 1 and 2 should be fill ment of Health and Mental H lant If item 27 is marked oth

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Department of important if any injury or once.

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Baltimore, Maryland

Director

Funeral

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To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by

State Registrar

Medicai

PANKAS R. DESAL, MD; 9017 LIBERTY ROKO, PANDALLS TOWN, MD21133 31. Date filed (Month, Dey, Year) 32. Registrer's Signature

6 Could not be determined

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signeture and the of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) July Davidson

NOING Paysician

1 Yes 2 No

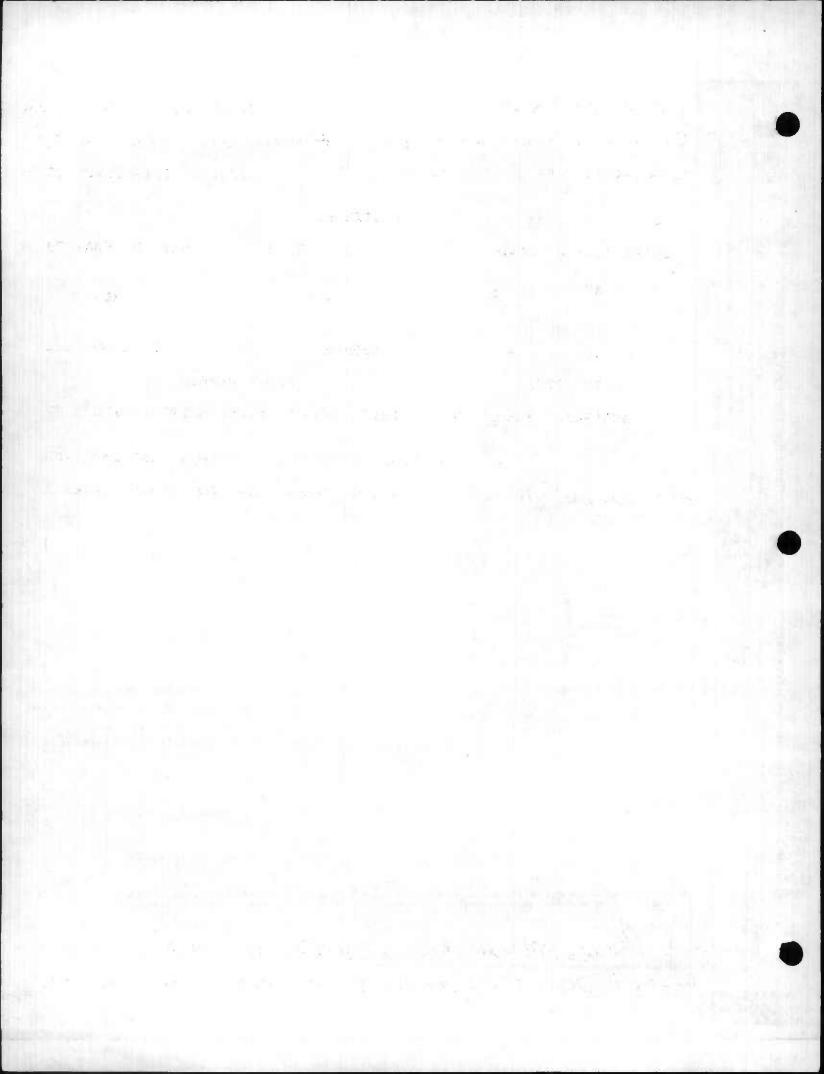
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the ceuse(a) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 40390

DHMH 16 Rev 6/95



Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, in Medical Examination must be notified at

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate by within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending Physical completely filled in by the funeral director, page 2 should be detached for use as the burner.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

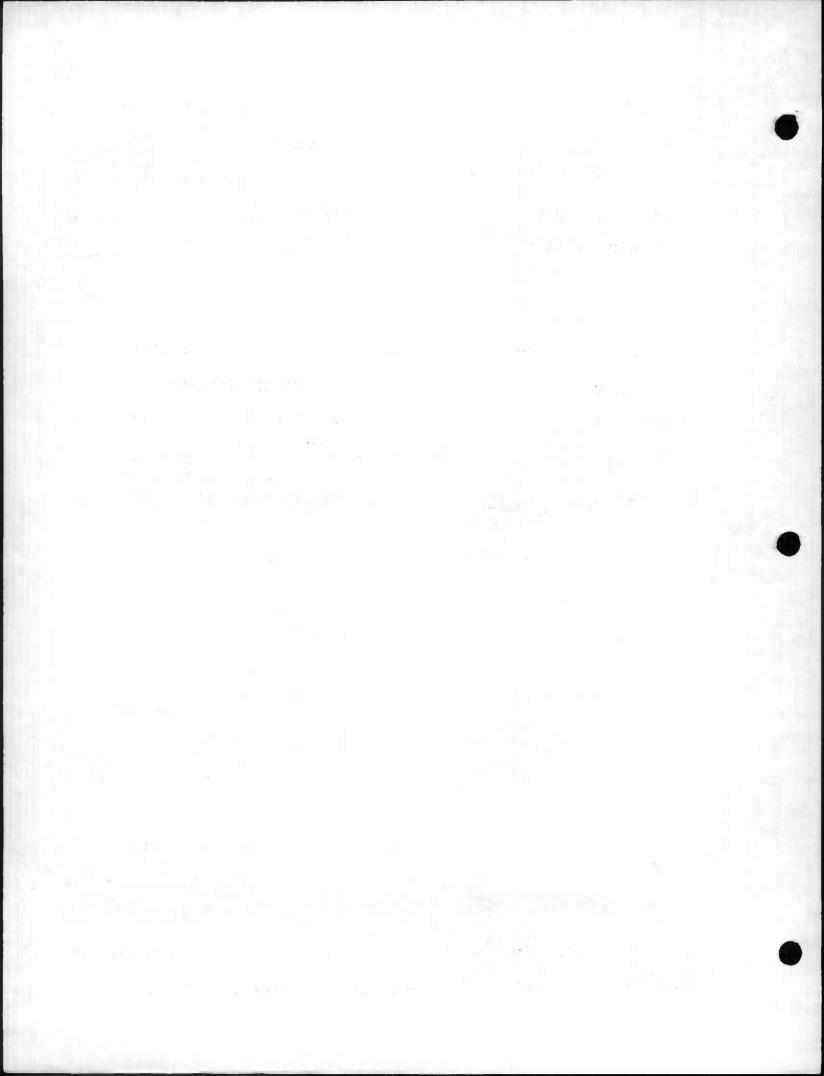
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ai er	4e. Fecilify Neme (If not Institution, give	street and number)					4b. City, Town,	or Location of Deet				11 1	
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3	3 Widowed 4 Divorced	Year or Detes:				7.	.,,		Specing	,			
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2	ARNOLD FORD												
	19a. Informant's Name/Relationship (7) NAOMI FORD	ype, Print)		19b. Mailing	g Address 6 F.T.	(Street	and Numberor	BALTO,	oer, City or Town, MD 212	Stata, Zi	p Coda)		
	20a. Method of Disposition		20h I	Place of Dispos									
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combiered by				_					s an autopsy ormed?	a	veilable	opsy findings prior to n of cause	
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	27. Manner of Death 1 □ Natural 5 □ Panding	28a. Date of Inju (Month, Da	y Year)	28b. Time of tnjury	2	8c. Inju Wo		-	how injury occur				
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141	29b. Signatura and title of certifier	mo yh	, ll	/	290		se number		29d. Dete signe				
	30. Name and address of parson who o	omplated ceusa of o	laath (Itar	n 23a) (Tuna F	Print)	oa	TE:		NOVEMBE	29,	199	/	
	30. Name and address of parson who co	omplated ceusa of d	^			eet	Raltin	none Mar					

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)
DEC 0 1199

32. Registrar's signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 7 Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Date of Deeth 3. Time of Death Month RONALD COLTON FONES 0845 AM November 25 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death AGNES Balti more HOSPITAL N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 1 M 2 F 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 215-24-7437 69 Yrs 01/10/1928 MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No BALTIMORE CATONSVILLE 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 1207 APT. F MARTIN COURT 21228 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Marital Stetus 1 Never Married 2 Merried 1 ☐ Yes 2XXNo Specify: f Yes, Give Year or Dates: Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) MERCY HOSPITAL DIATRY WORKER FOOD IND. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) HENRY COLTON FONES BERNICE Von MUNCHOW 19e. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) HENRY S. FONES/ BROTHER 1917 ORCHARD POINT ROAD PASADENA, MD 21122-5717 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☑ Other (Specify) ENTOMBMENT LOUDON PARK CEMETERY 11/29/97 BALTIMORE, MD 22. Name and Address of Fecility STERLING ASHTON FUNERAL HOME, INC. 11000m tela 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmedtate Cause (Final disease or condition resulting In death) Colon Concer, Metostasis To The Bone and lungs Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how thiury occurred 1 Naturat

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the Medical Examiner must be nothed at

Director

Funeral

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Completed

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

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Robo

25. Was case referred to medical examiner? 1 Yes 2 No

> 5 Pending 2 Accident Investigation 6 Could not be determined 3 Suicide 4 Homicide

28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end manner stated. (Check only one)

29b. Signeture end title of certifier

31. Date filed (Month, Dey, Yeer)

29a. Certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

Somer Kheini

MD

P 11703

NOY, 25. 1997

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) .900 CATON AVE. ST. AGNES HOSPITAL

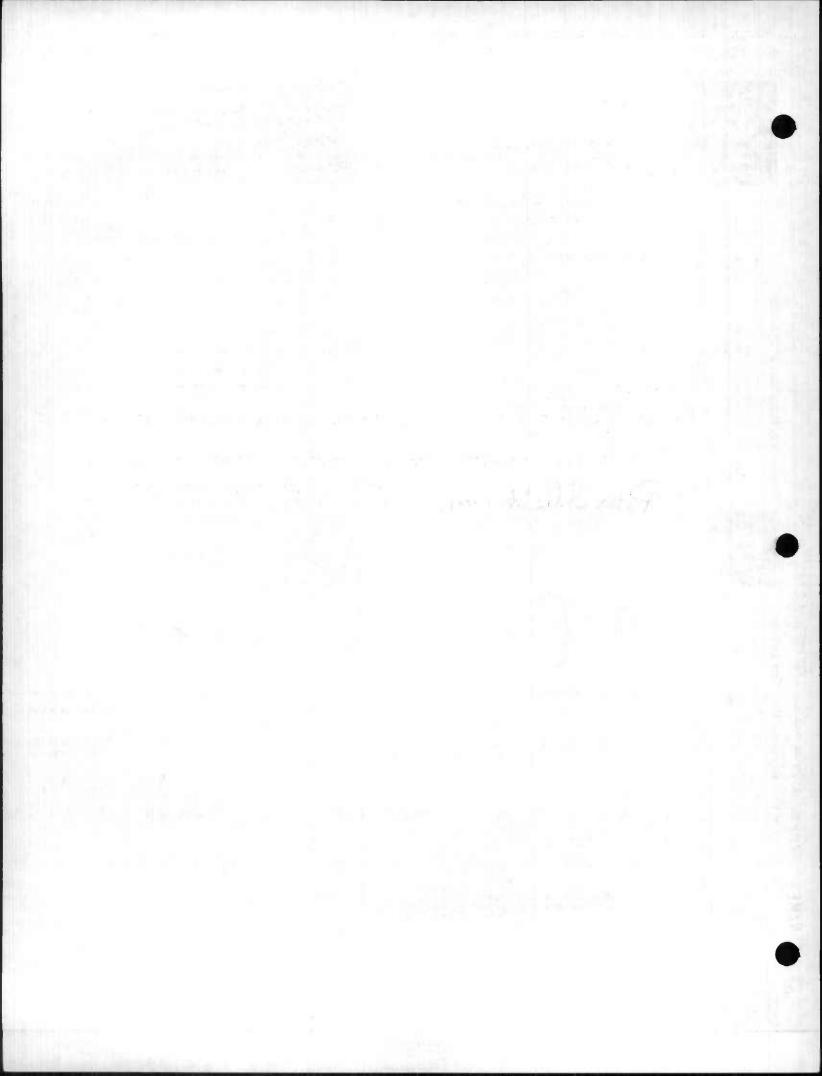
Baltimore, mD 21229 Dr. SAMIR KHEIRI

State Registrar

To the Fune completely f

Medical





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Defa of Death **Physician** Month Ronald Arthur Fromm 5;25AM NOVEMBER, 26 /Medical 4e. Fecility Nema (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner Baltimore** Stella Maris Hospice at Mercy 6. Sex 1 XM 2 ☐ F 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 8. Dafa of Birth (Month, Day, Year) 5. Social Sacurity Number 9. Birthpiaca (Stata or Foraign Country) **Funeral** 220 50 2051 49 Yrs Director Feb. 21,1948 Maryland Usual Rasidance of Dacedant the Maryland 10a Stete 10h County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Elkridge Maryland Howard 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21075 6007 Bauman Dr. United States 12. Wes Dacedanf Evar in U,S. Armed Forces? 1 ☐ Yas 22 No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indien, Black, White, etc. 11 Marifai Stafus Was Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) Nevar Marriad 2 Married 1 ☐ Yas 2X No Specify: White þ 3 ☐ Widowad 4 ☐ Divorced 15. Dacedant's Education 16a. Decadanf's Usuai Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Spacify only highast grada complated) filed within 7. Hygiene. Elamantary/Sacondery (0-12) Coilaga (1-4or 5+) Hair Salon Hairdresser 12 Pages 1 and 2 should be filed nent of Health and Mental Hygi nt: if item 27 is marked other 17. Fether's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumama) Jean Brashears William . Fromm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 6007 Baumaan Dr., Elkridge, MD Bonnie J. Metcalf / Sister 20b. Piece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 Cramation 3 Ramovel from Stata 11/28/97 Baltimore, Green Mount Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature M-Funeral Service Us 22. Nama and Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onset and Death Physician /Medical immadiata Cause (Finai Curhossis Hepatro ~ 10 years diseasa or condition rasulting in death) Examiner Due to (or es e consequenca of) Unknown Henzishs physician and s the burief-trans Sequantially list conditions, if any, leading to immadiata ceusa. Enter Underlying Cause (Diseesa or injury that initiated avants rasulting in deeth) Last Dua to (or as a consequence of) Physician/Medicai Dua to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causs of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Immune Deforences Àq 24b. Wara autopsy findings available prior to Completed 24e. Wes an autopsy complation of causa of death? 1 Yes 2K No 1 ☐ Yas 2 ☐ No certificate Division of Vital Attending Physician: 25. Was cese rafarrad to medical axaminar? Be 26. Pleca of Death (Chack only ona) Hospital: 1 | Impafient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 Yas 25 No ပ this unerel 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 28d. Dascribe how injury occurred 28b. Time of Certification: To the Hospital or Attending within 24 hours after deeth.
To the Funeral Director: Aftronominately filled in by the fur Natural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 3 Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Piece of Injury - At home, farm, streaf, factory, office building, atc. (Specify) 4 Homicida Cartifying Physician: To the best of my knowledga, death occurred at the time, dete and piece, end due to the ceusa(s) end manner es steted.

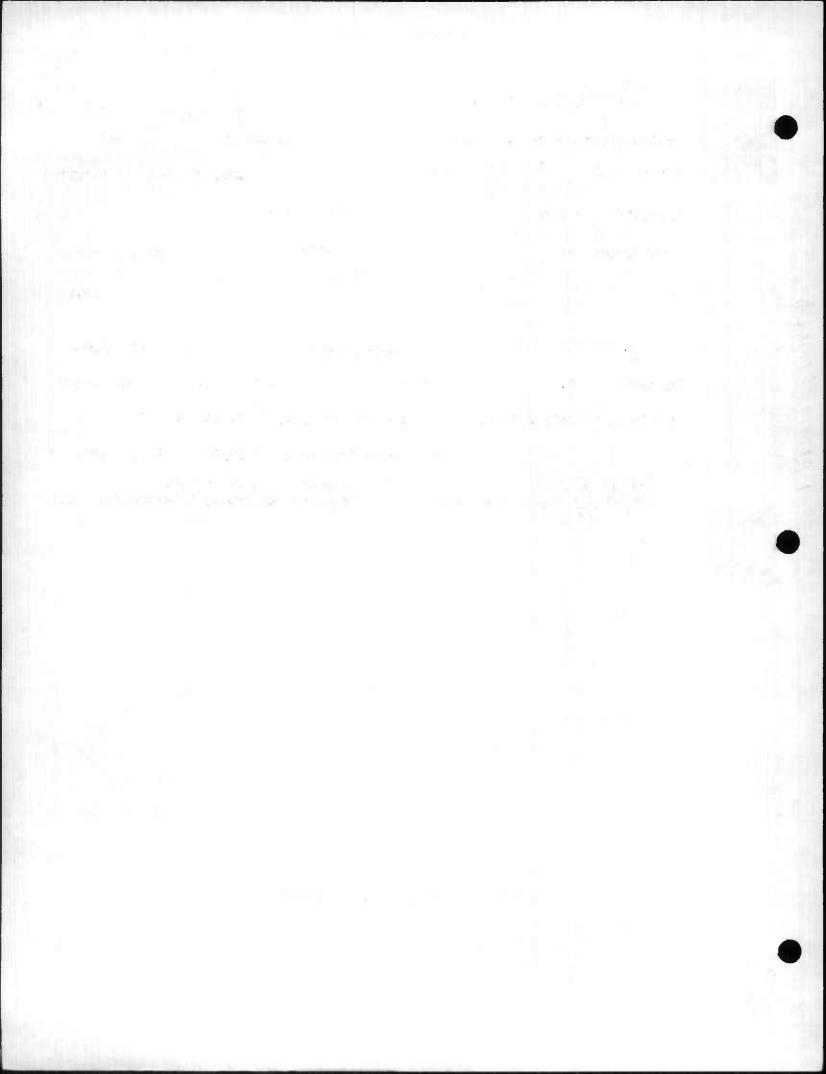
| Medical Exeminer: On the best of axaminetion end/or investigation, in my opinion, daath occurred at the time, date and piace, and due to the causa(s) and manner stated. Medicai 29a. Certifier 29d. Defe signed (Month, Day, Year) 29b. Signafura and titla of certifiar 29c. License number Dann un November 26, 1997 040480 7672 Belgir RA 30. Nema and addrass of person who complated ceusa of death (item 23a) (Type, Print) FERNANDO FERRO, MD 34 No Mp 21236 31. Date fliad (Month, Day, Year)
DEC 0 1 19 32 Registrar's Signatura State

wa Davidson-Randale

DHMH 16 Rev 6/95

Registrar

FROMM, RONALD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day November 1997 10:05pm NORMAN J. FOUNTAIN 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death TOWSON If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) GILCHRIST CENTER BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1€M 2□ F Months Yrs. 214-03-5424 Usual Residence of Decedent 86 MAY 4, 1911 MARYLAND 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND BALTIMORE CATONSVILLE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code U.S.A. 14. Race - American Indian, Black, White, etc. 2 WINESAP COURT APARTMENT H 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorcad 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUTCHER MEAT COMPANY 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HOWARD E. FOUNTAIN MARY E. HOGAN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 WINESAP COURT APT. H, CATONSVILLE, MD 21228 IRENE E. FOUNTAIN, WIFE 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Buriel 2 ☐ Cremation 3 ☐ Ramovel from State MEADOWRIDGE MEMORIAL PARK12/1/97 ELKRIDGE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 21. Signature of Funeral Service Licansae la Than L Lenn 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiretory arrest, shock, or heef failure. List only one cause on each line. Onset and Death Immediate Causa (Finel diseasa or condition resulting In death) a end-stage obstructive lung disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of) Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heart failure 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Panding investigation 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be datermined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida

Examiner physician and the buriel-transit certificate be exec Box 68760, 98 esn has this

Physician/Medical by Completed

29a. Certifier

(Check only

Physician

* /Medical

Examiner

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Funeral

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Funeral

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tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Modical Examinat must be notified at

should be filed within 72 hours efter and Mental Hygiene. marked other than "natural", or its

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permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra

Physician

/Medical **Examiner**

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Orman

the Maryland

death

P.O. Division of Vital Records, Attending To the Hospital of within 24 hours at To the F complete

> State Registrar

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🔁 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number

Killey mo

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November 27, 1997

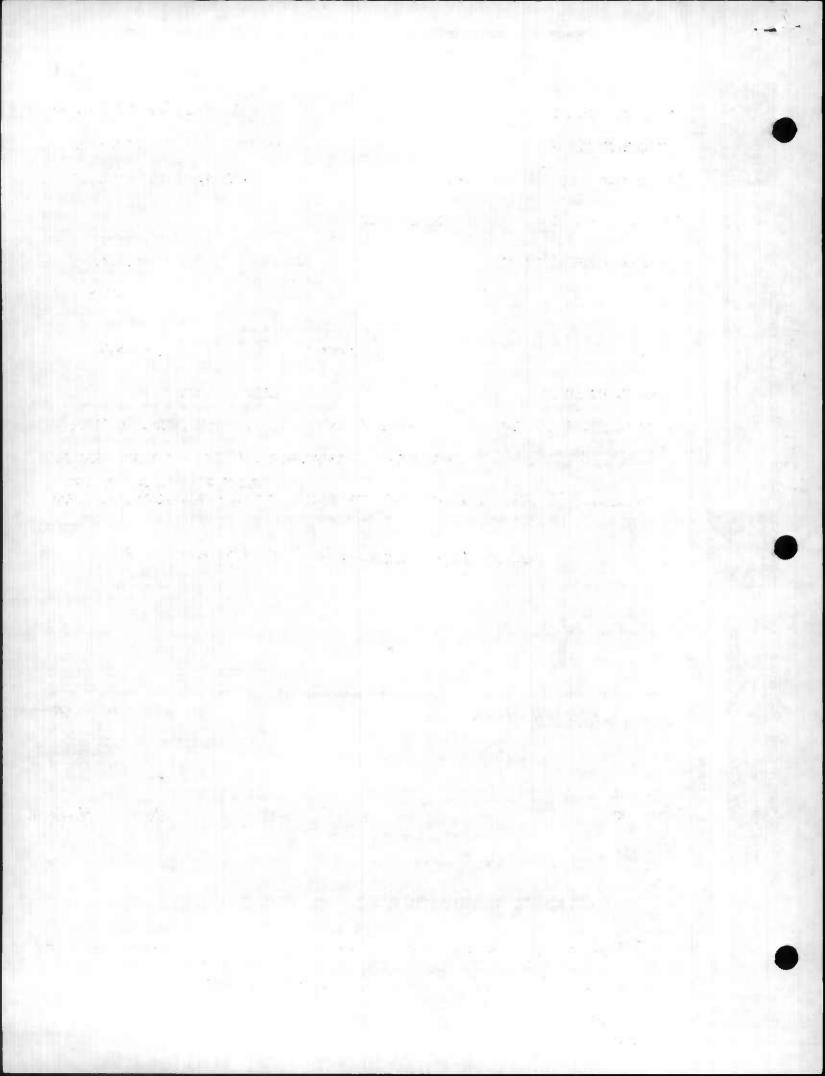
30. Name and address of person who completed cause of speth (Item 23e) (Type, Print) W. A. Riley

0 1 1997

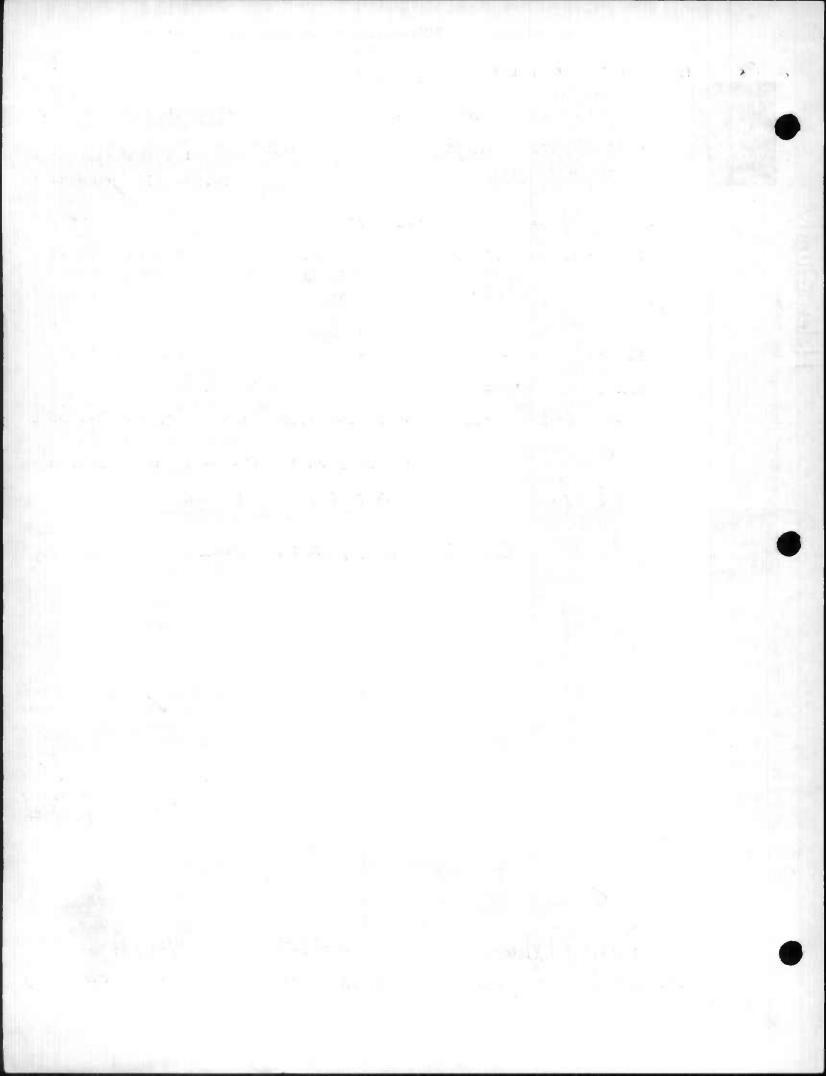
6701 N. Charles St. Balto. Md. 21204 GBMC 31. Date filed (Month, Dey, Year)
DEC 0 1 32. Registrar's Signature

Suha Davidson-Randalle

DHMH 16 Rev 6/95



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	The second of the state of the	Lusty				Month	Day	Year
ai er	4a. Facility Name (Find institution, s	MARITA JOI give street and number)	AN GU	NDY	4b. City, Town, or I	NownBe		97 Z:20 of Deeth
	MERCY @ S 5. Social Security Number 212-34-9669	TELLA MAR. Sex 7. Age (II	IS n yrs. last birthday 61 Yrs.	y) If Under 1 Yea Months Days		(Month, Da		N/A 9. Birthplace (State or Country) BALTIMO
	Usual Residence of Decedent 10e. State 10b. County	10	Dc. City, Town or L	ocation		110111	,	10d. Inside City
5	10.00							1 Yes 2
Funeral Director	MD 10e. Street and Number	na	BAL	TIMORE 101. Zip Code			10g. Citizen of W	2121
Ē	3528 EDMON	DSON AVENU	JE		1229		UNITE	
nera	11. Marital Status	12. Was Decedent Eve	r in U,S. 13	. Was Decedent of	Hispanic Orlgin? (S ben, Mexican, Puert	pecify Yes or No	- 14. Rece	- American Indian,
2	1 Never Married 2 Married 3 Mydowed 4 Divorced	Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 🕅		o Hican, etc.)	Specify:	k, White, etc. BLACK
Completed	15. Decedent's (Specify only highest of		16a. Decr	edent's Usuai Occu	ipation	kina	16b. Kind of Bu	siness/industry
mple	Elementery/Secondary (0-12)	College (1-4or 5+)			e during most of worked)	9		
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2	JAMES R. 19a. Informant's Name/Reletionship		10h Mai	Nine Address (Otro	et and Number or Ru			Ctota Zin Codel
		RIBER-Daug			ONDSON			IMORE, MD#
	20a. Method of Disposition		20b. Placa of Disp	position (Name of		Dete	20c. Location - (City or Town, State
	1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State		ematory or other pl		11 20	7 57	MIMODE ME
	21. Signature of Funeral Service Lic		METRO	CREMA 22. Name and Addr		11-28-9	7/ BAL	TIMORE, MD
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	23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused the	1					Approximate
	shock, or heart failure. List on	ly one cause on each line.				, , , ,		Interval Betwee
	Immediate Cause (Final	Centric	O Can	1ces /1	iterine 1	Cancer		un han a
	disease or condition resulting In death)	a	e to (or es a conse					wideria
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Examiner	Sequentially list conditions,	Due Due	e to (or es e conse	equence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	6						
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	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause g	iven in Pert i.		/	3 ☐ Probably 4 ☐ U
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State of Maryland / Department of Health and Mental Hygiene Item: 18 Per FH Film G-754 12-4-97RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** MARY GIERARD 1:20 pm NOVEMBER 1997 /Medical Baltimore

| H Under 1 Yaar | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year)
| April 24,] 4a. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Bayview Medical Center 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthpleca (Steta or Foreign Country) **Funeral** 1□ M 2♥ F Yrs. Director 215-03-4450 88 1909 Maryland Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23s or 28s-f show 1 Vas 2 No Director Maryland N/A **Baltimore** 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? filed within 72 hours after death with 5507 Craig Avenue 21212 U.S.A. Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Bleck, White, atc. 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorcad the Medical 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within nant of Heelth and Mentel Hygiena. Int: If Item 27 ia marked other than ' Iry or other traumatic event, Ira Ma Elamantary/Secondary (0-12) Coilaga (1-4or 5+) 10 years Homemaker Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) BURNS Be Joseph Callahan Mary Ellen Byrnes 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Mary Anne Byan (daughter) 2266 Cherokee Dr. Westminster, Maryland 21157 20b. Pieca of Disposition (Neme of cematary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Pages Department of Important: If it any Injury or one St. Mary's Church Cemetery 12-1-97 Baltimore, Maryland 21. Signeture of Funerel Sarvice Licensee 22. Name and Address of Fecility
Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 unas Pert1. Enter the disaese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. (List only one cause on each line.) Approximata intervei Between Onsat end Death **Physician** /Medicai immediata Ceuse (Finel 72 days a Acute Renal Failure diseese or condition resulting In deeth) Examiner Due to (or as a consequenca of) Examiner Cardiomyopathy Sequantielly list conditions, if eny, leeding to Immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Last Due to (or es e consequenca of) Box 68760, Physician/Medical The law requires that the death certificate Due to (or as a consequence of) for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2⊠No 3 Probably 4 Unknown Chronic atrial fibrillation ate has been signed paga 2 should be de Records, Be Completed by 24e. Wes en autopsy performed? 24b. Were eutopsy findings aveileble prior to completion of causa of daeth? certificate 1 ☐ Yes 2 ☑ No of Vital Hospital or Attanding Physician: 25. Wes casa referred to medical 26. Pleca of Death (Check only one) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yes 2 No Certification: To 1⊠Inpatient 2□ER/Outpetient 3□ DOA this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Affar Division 5 Pending investigation 1 Neturel s after death. 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datermined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Steta) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Spacify) filled in by 4 Homicide 24 hours 1 Medicat Examiner: To the best of my knowledge, death occurred at the time, deta end place, and due to the cause(s) end manner as stated.

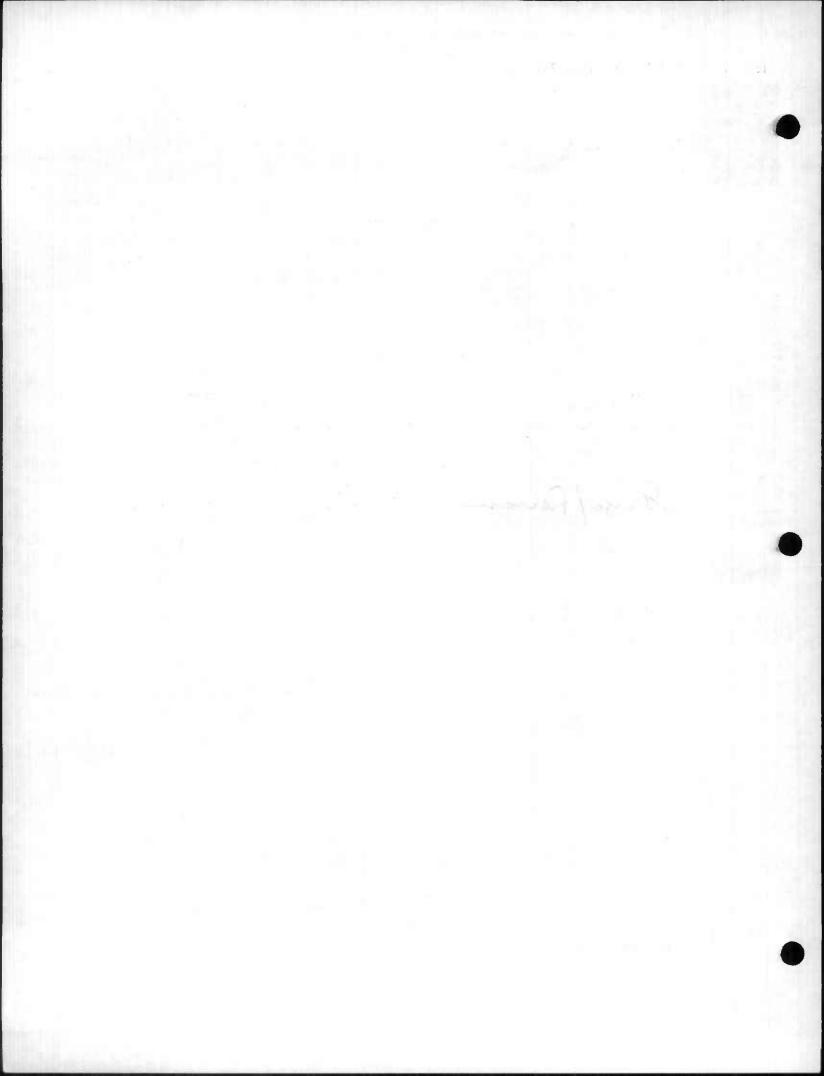
2 Medicat Examiner: On the best of exemination and/or investigation, in my opinion, deeth occurred at the time, deta end place, and due to the cause(s) end manner stated. Medical 29e. Cartifian (Check only one) To the Vithin 2 29b. Signeture end titla of certifier 29d. Data signed (Month, Dey, Year) 29c. License number Male Dalman, HD JHH N 3303 November 27, 1997

State Registrar

31. Data filed (Month, Dey, Year) DEC 0 1 1997

601 N. Wolfe St. tower 110, the Johns Hapkins Hospital 32. Registrar's Signeture who Davidson-Mandell

30. Name end eddrass of person who completed causa of deeth (Item 23e) (Type, Print)

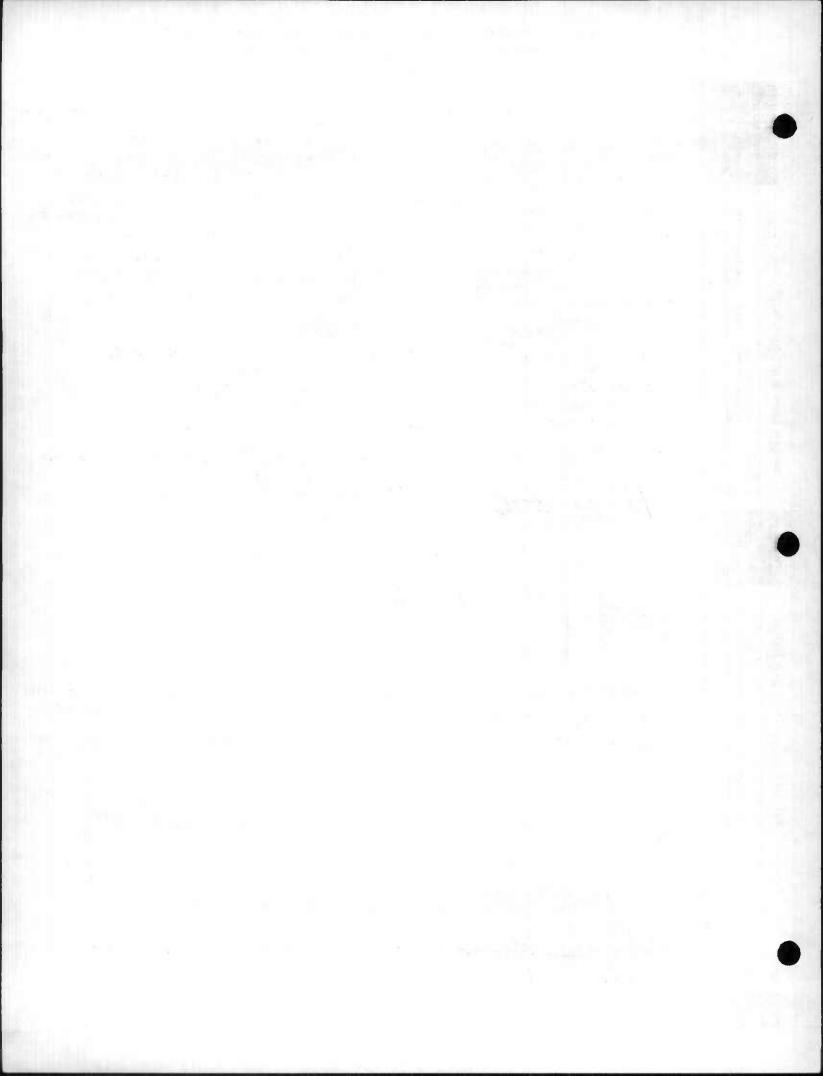


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 4a. Facility Name (If not institution, give street and number, 11 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Baltimore N/A Home Nousing Marrel If Under 1 Year Hunder 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1□M 25 F Months Deys Yrs. Director 229-22-0614 FEB 23, 1921 VA 76 Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be nothing at MD N/A BALTO Director 1 X Xes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1936 E EAGER ST items 23a 21213 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item and Injury or other treumatic event, tre Medical Examina 2008. 1 Never Married 2 Married 1 ☐ Yes Z☐No It Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 þ Specify: BLACK 3 Wowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEKEEPING HOSPITAL 7th N/A 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be CHARLIE JONES ANNIE BROGDON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RAWLEIGH JONES 5819 THE ALAMEDA BALTO, MD 21239 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition DEC 2 20c. Location - City or Town, Stete 1 ☐ Burlei 2 ☐ Cremetion 3 ☐ Removel trom State 1997 4 Donetion 5 DOther (Specify) OWINGS MILLS, MD GARRISON FOREST VACEM 22. Name end Address of Fecility BETTS FUNERAL HOME 21. Signature of funeral Service Licenses 1129 N. CAROLINE ST BALTO, MD 21213 23e. Pert f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Physician/Medical Due to (or es e consequence ot): The law requires that the death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t Varcular Ornare 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 □ Yes 2 □ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case reterred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To nours efter death.

neral Director: After this y filled in by the funeral di 27. Manner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 DNaturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ SuicIde 28e. Pleca of Injury - At home, ferm, street, tactory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 D Homicide Certifying Physicten: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es steted.

2 Medicat Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner steted. 29a. Certifier Medical (Check only one) 29b. Signeture end title ot certitier 29c. License number 29d. Date signed (Month, Day, Year) Cymacy Attending Doctor D 21684 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) SIO9 RITCHIR LOVY. PASADENA, MO21122 N CYRIAC-M-D 31. Dete tiled (Month, Day Year) 0 1 19972. Registrer Signature Junior Funders State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 5 per F.M G-754 12/2/97 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Yeer Μ. Artemus Grady Nov. 97 4:29am /Medical 4a. Facility Name (If not Institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore 5. Social Security Number 4597 If Under 1 Yaar If Under 24 Hrs.

Months Deys Hours Min. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F Deys Hours 219-28-4599 Director 04 - 26 - 33NC Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumstic event, the Medical Examiner must be notified at Md. NA Baltimore Director 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1439 Stonewood Road 21239 USA deeth 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, permit. Peges 1 and 2 should be filed within 72 hours after 1 Department of Health and Mantal Hygiene. Important: If Item 27 is merked other than "natural", or iten any injury or other traumatic event, the Medical Examines once. Black White etc. 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes ANO Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) City of Baltimore 12th Grade Supervisor 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) OL Maxwell A. Grady Irma 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21212 Grady 1048 Tunbridge Road Baltimore, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Buriel 2 Cremetion 3 Removal from State Arbutus Mem. Pk. Cem. 11-28-97 Arbutus, Md. 21 Signature of Funeral Service Lice 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Part I. Enter the diseasa, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or raspiretory arrast, shock, or hear feilure. List only one ceuse on each line. **Physician** /Medical Immediete Ceusa (Final disease or condition resulting in death) ~ 30 40 monte Cardio respiratory **Examiner** Examiner physician end the burial-transit Sequantially list conditions, if any, leeding to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initiated events rasulting In deeth) Lest Due to (or es e consequenca of) be axecul Physician/Medical Sete Due to (or es e consequence of): USa Po Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by the 1 | Yes 2 | No 3 | Probably 4 | Unknown Hepatic circhosis à 24b. Were autopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performad? Completed peen has 2 1 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical axaminer? Be 26. Placa of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? After 1 Neturel 5 Pending Investigation death. 1 ☐ Yes 2 ☑ No after death Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, offica building, atc. (Specify) filled in by 4 Homicide Hospital 24 hours a 24 hours Funerel Medical 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to tha ceuse(s) end mannar as steted. (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. To the I within 2. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) D16587 30. Name and address of person who complet cause of death (Item 23a) (Type, Print) Loch Raver Blod, Bolomor, MD 21239 5601 hangino

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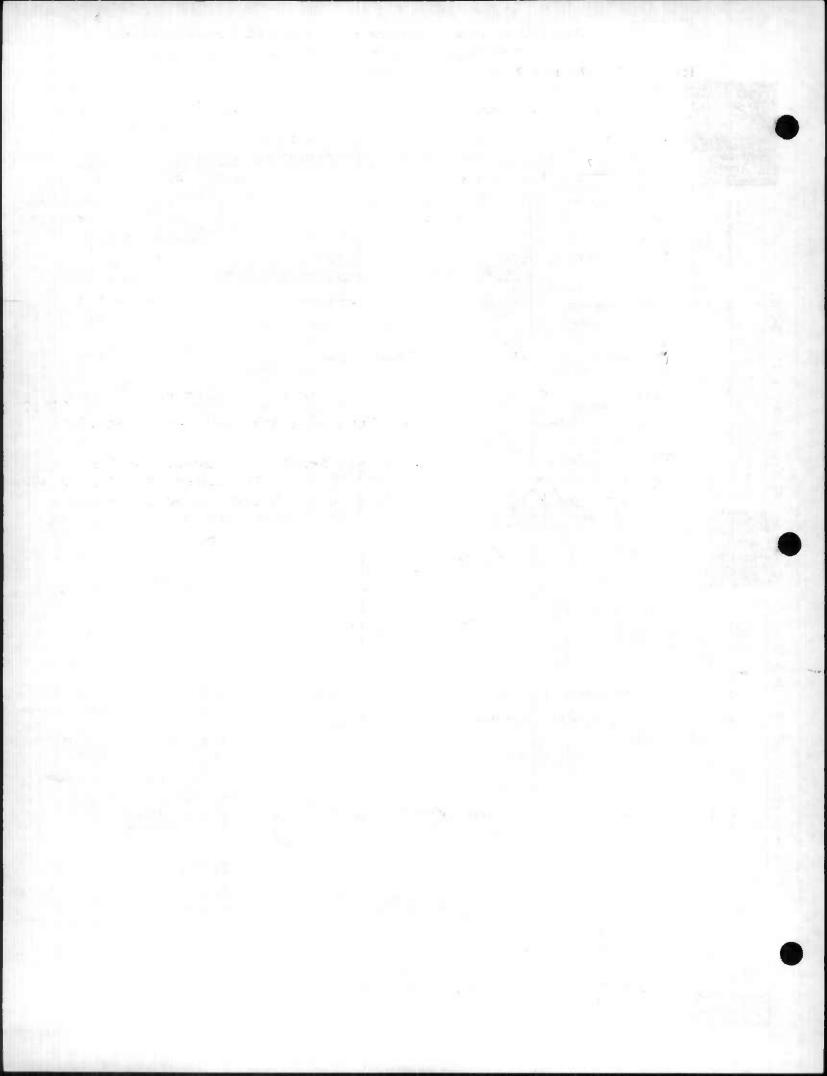
Registrar

31. Date filed (Month, Day, Year)

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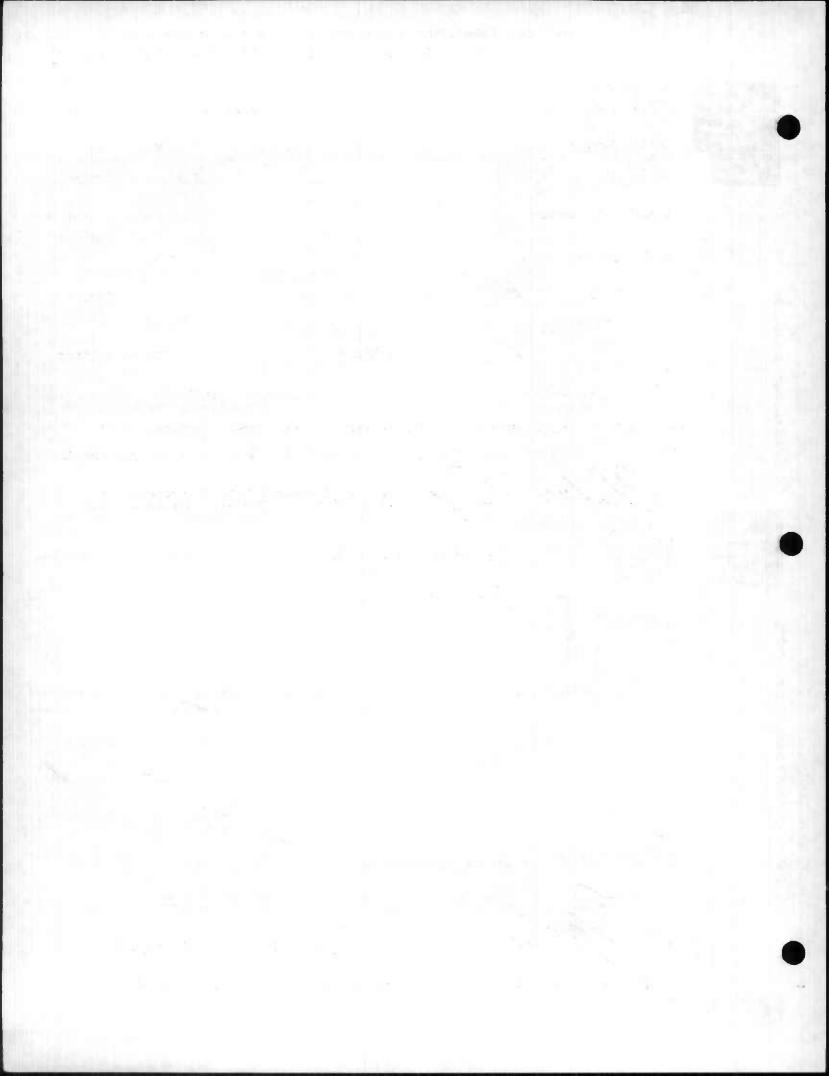
32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Wilbur 1997 James Graham November 21, 2:10 PM /Medical 4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1132 Foxwood Lane Baltimore If Under 1 Yaar If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Sociei Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1€M 2□ F Yrs. Director 215-30-1818 63 7-17-1934 Maryland Usual Residence of Decedent the Meryland 10c. City, Town or Location 10b. County 10d. Inside City Limits Hem 27 Is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Maryland Baltimore Essex 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zlp Coda 10g. Citizen of Whet Country? with 1132 Foxwood Lane 21221 death v U.S.A. Funeral permit. Peges 1 end 2 should be filed within 72 hours after dea Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items any Injury or other traumatic event, the Mexical Examination once. 12. Wes Decedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Merital Status Biack, White, etc. 1 G Yes 2 No 1955 If Yes, Give 1955 Yaar or Dates: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Eiementery/Secondary (0-12) Machinist Communications 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Leroy B. Graham Bertha Rebel 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs Edith W. Graham (Wife)
20a. Method of Disposition Lane, Essex, Maryland 21221 1132 Foxwood 20b. Place of Disposition (Name of cametery, crematory or other place)
Oak Lawn Cemetery 20c. Location - City or Town, Stata Dete X Burial 2 □ Cramation 3 □ Removal from Stete 4 □ Donation 5 □ Other (Specify) 11-25-97 Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home Of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each lipe. Approximete Intervel Batween Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner cancer ettending physicien end for use es the buriel-transit certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting In deeth) Last Due to (or as e consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 1 188 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of causa of death? 24e. Was an autopsy performed? Completed peen hes 2 No certificate 1 Yes 2 LIN 1 Yes 25. Wes case referred to medical exeminer? Be 28. Piece of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Hesidence 8 Other (Specify) 1 Yes 2 10 10 1 Inpetient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After 1 UNaturei 5 Pending 1 Yes 2 HNo investigetion 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifiar 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of 036131 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Michael Brave, 7600 Osler Drive Towson, MD 21204 M.D. 31. Date filed (Month, Day, Year) 32. Redistrer's Signature 0 1 1997 rilia Davidson -Mandell Registrar



State of Maryland / Department of Health and Mental Hygiene() Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 10 50 **Physician** PEARL GOET7 NOV /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner PAUL PLACE BALTIMORE n/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
MAR. 13, 1907 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2 F Deys Hours 214-40-4263 MARYLAND 90 Yrs Director Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inaide City Limits 7 le marked other than "natural", or Items 23a or 28a-f shov traumstic event, the Mexical Examinar must be notified at Director 1X Yes 2 No MARYLAND BALTIMORE nlA 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? ROLAND PARK PLACE Funeral 830 WEST 40TH STREET 21211 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever In U,S.
Armed Forces?
1 □ Yes 22 No
If Yes, Give
Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XNo Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "n any fijury or other traumetic event, tra Hax any fijury or other traumetic event, tra Hax any blots. College (1-4or 5+) Elementary/Secondary (0-12) SCHOOL TEACHER BALTIMORE CITY SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) EDWARD C. WALTER NELLIE E. COSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 102 W. PENNSYLVANIA AVENUE, TOWSON, MD 21204 CHARLES F. STEIN, ATTORNEY 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 12/1/97 LOUDON PARK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 22. Name and Address of Fecility WITZKE FUNERAL HOMES, INC. 21. Slanature of Funerel Servica Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final 10 hours disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine physician and the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Ethernise signed t Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1□ Yes 20 No 1 ☐ Yes 2 ☐ No certificate Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Beath 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Netural aftar death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft. To the Funeral Discompletaly filled in 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number In Stabelle Mar gregn or) Nehember 26, 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VT. ISABELLE MACGREGOR, ROLAND PARK PLACE, 830W 404 STREET, BALTIMORE, MDQ1210 31. Dete liled (Month, Pay, Year) DEC 0 1 1997 32. Registrar's Signature State

Julia Davidson-Randalle

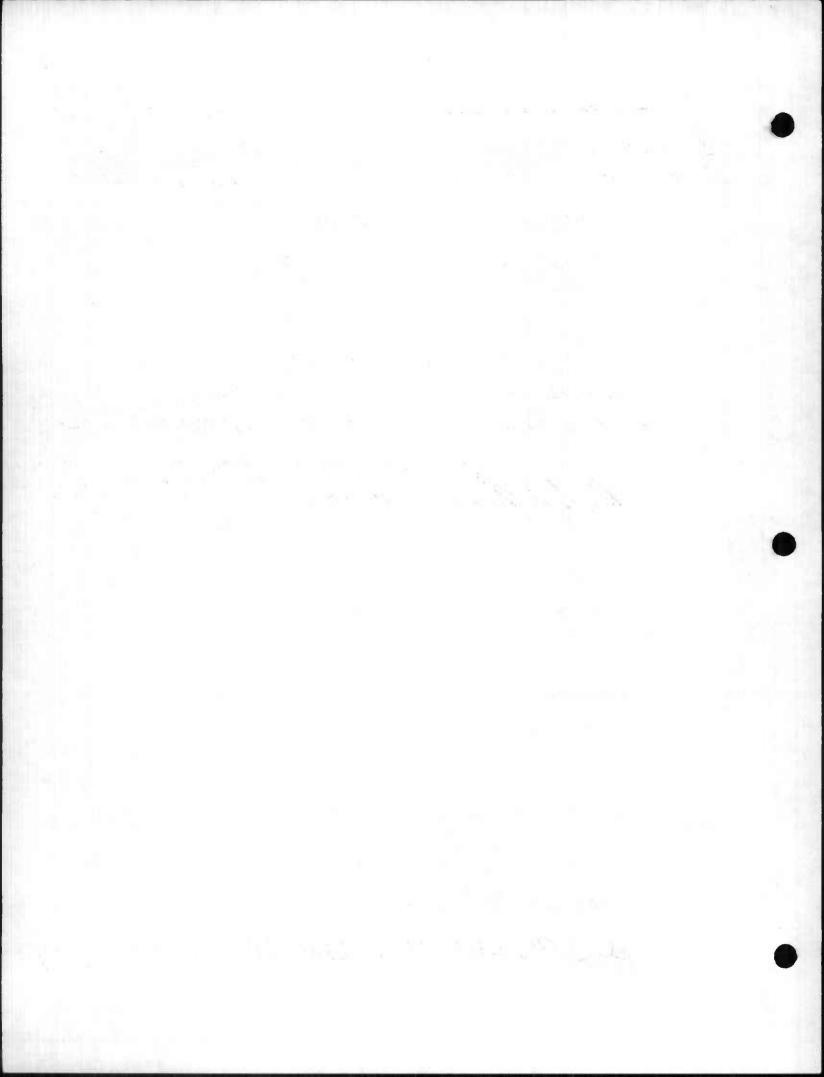
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State of Maryland / Department of Health and Mental Hygiene 9 7 3 5 9

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/Medic Examin	_	4a. Facility Neme (If not institution, give street and number)				4b. City, Town, or Location of Death 4c. County of Death			O. Jopan			
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uneral		5. Social Security N	lumber 6. 9	Sex 7. Ag	e (In yrs. last	birthday) If Und	der 1 Year	If Under 24 Hrs	8. Dete of Birth		9. Birthpled	ce (State or Forei
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Mo to		10a. State	10b. County		10c. City, To	own or Location					10d	. Inside City Lim
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E CO	ne	11. Meritei Stetus		12. Was Decedent I Armed Forces?	Ever in U,S.	13. Wes De	cedent of I		Specify Yes or No- rto Rican, etc.)	14. Rec	e - American ck, White, etc	
important: if item 27 is marked other than "netural", or items 23s or 28s4 shov any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Merri	ied 2 Married 4 Divorced	1 Yes 24 N If Yes, Give Yeer or Detes:	10		2 No		to moun, ord.)	Specify		
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am 27 other tr		ROBERT K.	GORDY,	HUSBAND	_ 1	1918 OLD	FRED	ERICK RO	AD, CATO	VSVILLE	, MD 2	1228
r oth		20a. Method of Disp		Removel from State	20b. Plece ceme	of Disposition (for other, crematory of	Verne of or other ple	ce)	Dete	20c. Location -	City or Town	, State
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Important: I any injury o once.		21. Signature of Fu	neral Service Lice	nsoe /					ITZKE FU			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month **Physician** SR. MARY LUCY HAMILTON, M.H.S.H. November 21, 1997 10:08 PM /Medicai 4e. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE VILLA - JOINT RETIREMENT CONVENT Rodgers Forge
or If Under 24 Hrs. 8. Date
s Hours Min. (Mo Baltimore County If Under 1 Yaar 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□M 2₽F 89 Yrs. Director 577-68-0377 Nov. 8, 1908 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show show 1 ☐ Yes 2 No Directo Maryland Baltimore County Rodgers Forge the 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mantal Hygiena. Important: if Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Modical Examinating and Injury or other traumatic event, the Modical Examinating and Injury or other traumatic event, the Modical Examinating and Injury or other traumatic event, the Modical Examinating and Injury or other traumatic event, the Modical Examinating and Injury or other traumatic event, the Modical Examinating and Injury or other traumatic events. 6806 Bellona Avenue Funeral 21212 USA 14. Race - American Indian, Bieck, Whita, atc. 12. Wes Decedent Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Datas: 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Christian Religion 5+ Religious Nun 17. Fethar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be 10 James Neale Hamilton Mary Emily Matthews 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Name/Reletionship (Type, Print) Mission Helpers of the Sacred 20b. Place of Disposition (Neme of cometery, cremetory or other place)

1001 W. Joppa Road, Towson, Maryland 21204
20c. Location - City or Town, Stete Heart Motherhouse 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) New Cathedral Cemetery 11/25/97 Baltimore, Maryland 21. Significant Funeral Service Ligaret 22. Name and Address of Fecility Xawson Mitchell-Wiedefeld Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feilura. List only one cause on each line. Martin D. Lawson interval Between Onset and Death **Physician** /Medical immediete Ceuse (Finel disease or condition resulting in death) old Examiner Due to (or es a consequence of): Examiner Hypohyroidism Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Right sded cesels vascular Accident 68760 Physician/Medical Due to (or as e consequence of): Box Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown Records. by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was an eutopsy periormed? Completed peed page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No Investigetion 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as steted. 29a. Certifier Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) M.D BS 55-71585 11124197 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

YRATIBHA SHARMA 301, ST PAULS STREET, SUITE 403-BALT IM ORE - MD-ZIIVZ PRATIBHA SHARMA

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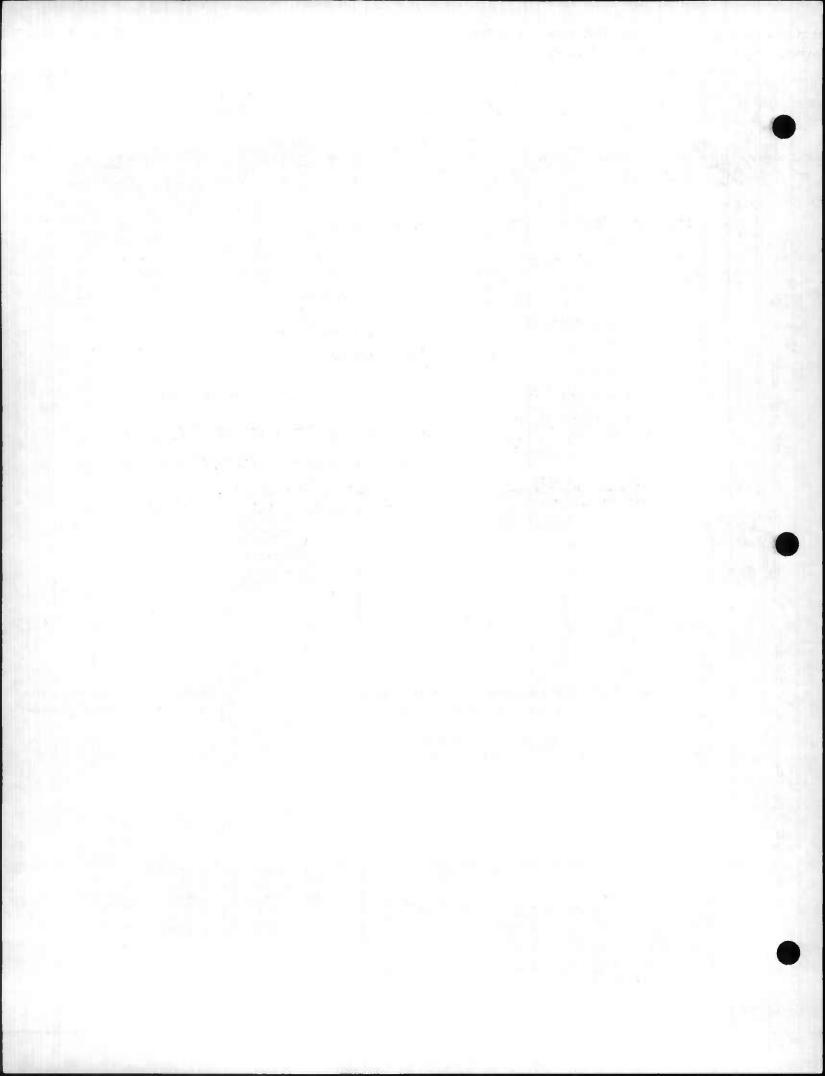
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Registrar

31. Date filed (Month, Day, Yeer)

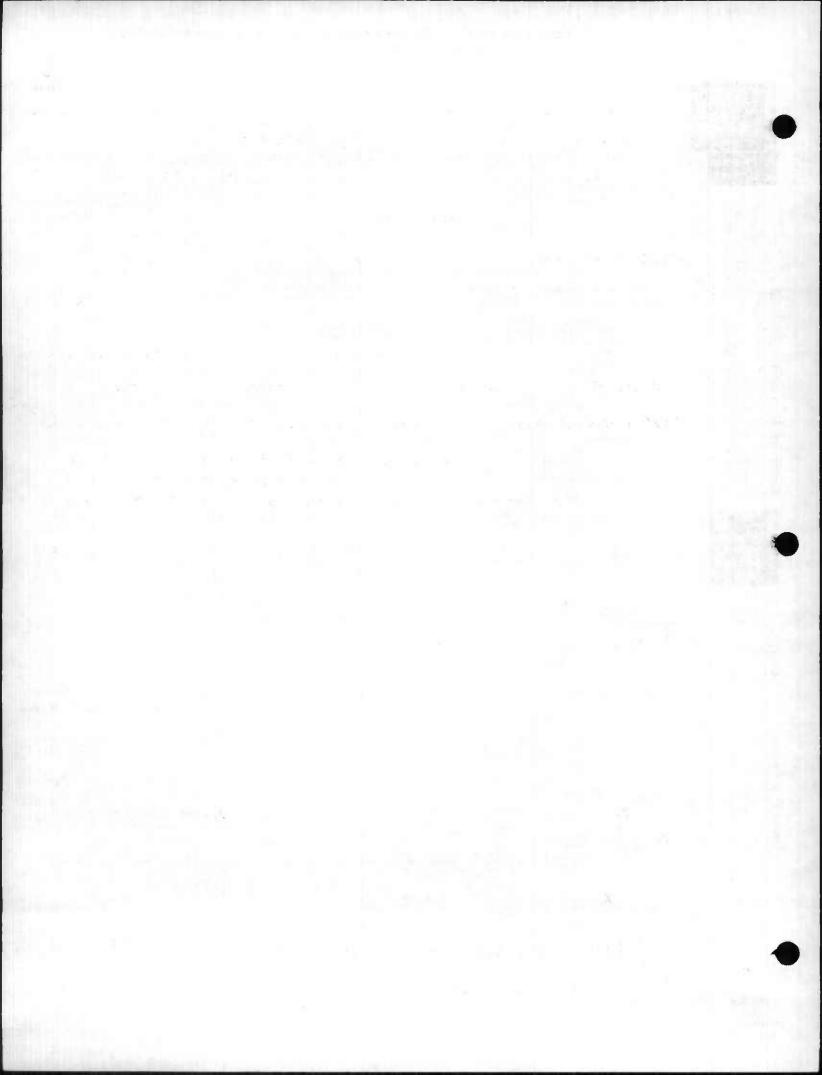
32. Registrer's Signeture

ina Daydson-Randell



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					C	ertifica	ate of	Death			Reg. No.	3	5959
Physician		I. Decedent's Name (First, Middle, Last)						2	2. Dete of De Month		Yeer	3. Time of Death
/Medical Examiner		Bettie Rut	street and number)							Nov	. 28,	97 of Death	3:25pm
		3615 Elmley				1 10.17			imor	_		N	
uneral irector		5. Social Security Number 6. Sec. 216-34-1157 Usual Residence of Decedent	THE OF XE	e (In yrs. las	st birthd Yrs	Month	ier 1 Year s Days	if Under 2	Min.	Dete of Bird (Month, De 05-1	y, Year)	9. Birthp Coun NC	lace (Stata or Foraign try)
No to	-	10a. Stele 10b. County		10c. City,	Town o	r Location						1	Od. Inside City Limits
o o		Md NA		Bal	tim	ore							1 Yas 2 □ No
at be normed		Oe. Street and Number 4615 Elmley Ave	20116				Zip Code	3			10g. Citizen of V		itry?
bottal Examiner must be notified at letted by Funeral Director			12. Was Decedent Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:		1	13. Was Dec If Yes, s		Hispenic Orlg an, Mexican	gin? (Speci , Puerto Ri	fy Yes or No can, etc.)		a - Americ k, White,	
ted pt		15. Decedent's Edu	cation		16a. De	ecedent's U	sual Occup	petion	of working		16b. Kind of Bu	siness/înc	dustry
other traumatic event, the Medical		(Specify only highest grade Elementary/Secondary (0-12) 9th Grade	Coilege (1-4or 5	5+)		Nurs		during most d)	or working		Nursin	ng F	acilitie
Be C		7. Fether's Neme (First, Middle, Last)						18. Mothe	r's Name (First, Middle,	Meldan Sumam	a)	
10		Richard	Nor	ris				V	era		Pay	ton	
E .		19a. informant's Name/Relationship (Ty	rpe, Print)							Routa Numbe	er, City or Town,	Stete, Zip	Code) 212
1 Per 1	-	Rachel Payton						y Ave	enue		timore		*
8	1	20a. Method of Disposition ★□ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	cerr	atary,	sposition (A crematory o Mem.	r othar pla	ce)	12-	Dete -01-9	20c. Location - 7 Randa		town, Stete
eny injury once.		21. Signature of Funeral Service License	P 0					ess of Facility	Dai			-	nd 21202
	+	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that coused	the death.							. North	AVE	Approximate
usi the bunal-transit unit position in the bunal-transit unit position in the bunal transit unit		resulting in death)	ENGO	MQ+/ Due to (or e			f):	vcer	و				a yens
Medical Ex							vnsequenca of):						
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icia i	F	Part II. Other significant conditions con	tributing to death b	ut not resulti	na in th	e underlying	cause di	ven in Part I		23b. Did	tobacco usa cor	ntributa to	the cause of death?
be catached for us by Physician/								VO() III 1 G.(. 1.		~ /			pably 4 Unknow
paga 2 should b										24a. Was perfo	an autopsy rmed?	ava	ere autopsy tindings allable prior to mpletion of cause death?
omp										10	res 20 No	10	Yes 2 No
director, paga To Be Com		25. Was case referred to medical						26. Piece	of Death (Check only o	na)		- / %
		examiner? 1 ☐ Yes 2 No	lospital: 1 🗆 Inpatie	nt 2 EF	VOutpa	tient 3	DOA Oti	her: 4 Nur	rsing Home	5 Resid	denca 6 Oth	er (Specify	y)
funera flon:		7. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day	ry Year) 28	8b. Tim Inju		28c. Inju Wo 1 [ryat rk?]Yes 2 □ N		d. Describe I	now injury occurr	ed	
completely filled in by the funeral Medical Certification:	3 Sulcide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rounding, etc.) City or Town, State)									l Routa Number,			
completaly filled		29a. Certifier (Check only one) 1 Certifying Phys	icien: To the best of her: On the basis of end menner sta	examination	dge, de	eth occurre r investigeti	ed at the ti	me, date end opinion, deet	d placa, and h occurred	d due to the at the time,	cause(s) and ma dete end plece, a	nner as st and due to	ated. the ceuse(s)
Me.		19b. Signature and title of certifier				2	9c. Licens	se number			29d. Dete signed	(Month,	Day, Year)
		> Jeffers 1	morgel	4 M	0-	Delta I	D50	2177			12/1	19)	
)		0. Name and address of person who co	olis	600	N	6/H	W	AIC	Sh	Bu	timore	MD	21287
State	3	11. Date flied (Month, Day, Year)	32. Registr	ar's Signatur	O News	Rande	22.						1100

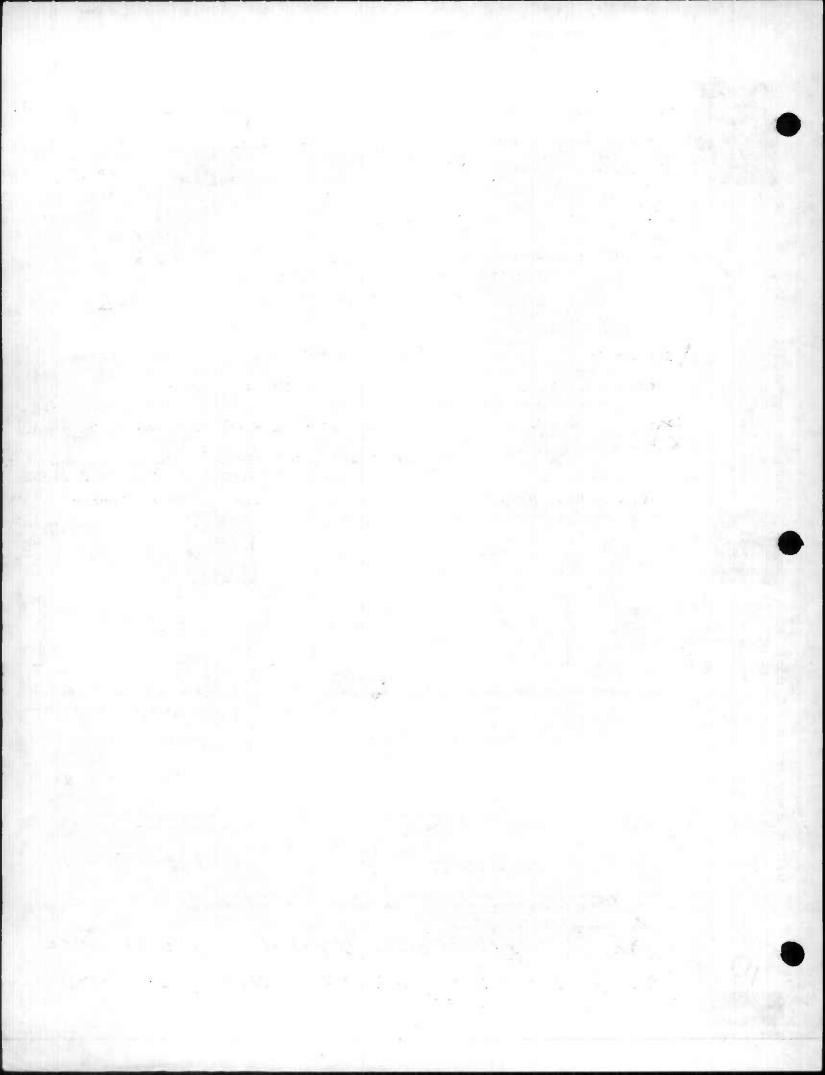


State of Maryland / Department of Health and Mental Hygiene 35960 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** NOU 11:10 P.M Mary Junia /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Keswick Nursing Home Baltimore NA 5. Social Security Number if Undar 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) 9. Birthpieca (Stete or Foreign **Funeral** Days 10 M 200 F Hours Country) MA 235 -58 - 7991 81 Yrs. Director 06/20/12 Usuei Residence of Decadent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene.

Important: If item 27 is merked other than "natural", or fiems 23a or 28a-f show any Injury or other traumetic evant, the Medical Examiner must be northed at once. 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. NA X⊠Yes 2□No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 700 West 41st. Street 21211 Funeral USA 12. Was Decedent Ever in U,S. Armed Forcas? 13. Wes Decedant of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No If Yes, Give Yeer or Dates: 21215-0020 1 Yas 2 No Specify. þ 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Social Worker Facilities 12th Grade Baltimore, Maryland 17. Fathar's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Be Forrest O. Irish Lenora Collins 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21218 19e. Informent's Neme/Reletionship (Type, Print) Mary Pat Clark 3911 Clover Hill Road Baltimore, Maryland 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stata βuriel 2 □ Cremetion 3 □ Removei from Stete New Cathedral Cem 11-28-97 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Md. Baltimore, Maryland 21202 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Keren m. (Coare WM.C. March FH 1101 E. North Avenue 23a. Part1. Entar the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one causa on each line. Approximete intervel Between Onsat and Death **Physician** Immediate Cause (Final disaase or condition resulting in deeth) /Medical 4 day eumomia Examiner Due to (or es e consequence of): Examiner the bunal-transit Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Physician/Medical The law requires that the death Pert II. Other significant conditions confributing to death buf not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o the signed by t Division of Vital Records. P. 1 Yes 2 No 3 Probably 4 Unknown ρ been si 24b. Were autopsy findings eveilebla prior to compiation of cause of deeth? Completed 24e. Wes en eutopsy performed? this certificate has 1 Yes 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) 1□ Yes No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Deeth Neturel 2 Accident Certification: 28d. Describe how Injury occurred After 5 Pending Investigation 1 Yes 2 No after death Director: / 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D edical Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) and manner as stated.

Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) and mennar stated. 29a, Certifian completely (Check only one) 29b. Signature and titia of certiff 29d. Data signed (Month, Day, Year) of person who completed cause of deeth (Item 23e) (Type, Print) Str Street BALTO 21211 32. Registra Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month NOV /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death Examiner JOSEPH RITCHIE HOSPICE

5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Data of Birth 9. Birthplaca (State or Foreign Months Days Hours Min. DEC. 31, 1943 BALTIMORE **Funeral** Director Usuai Rasidance of Dacedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ral", or itams 23a or 28a-f show Examiner must be notified at 1 Yesx2 No Director MD BALTIMORE NA 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3405 GARRISON STATES BL VD. 21215 UNITED Peges 1 and 2 should be filed within 72 hours after death \\
nent of Health and Mental Hygiere.\\
ant: if item 77 is marked other than "natural", or itams 23.\\
ant: if item 20 is marked other than "natural", or itams 23.\\
anti-ity or other traumatic avant, fire Nedesi Exercise mustry or other traumatic avant, fire Nedesi Exercise mustry.\\
anti-item 10 is not the Nedesi Exercise mustry or other traumatic avant, fire Nedesi Exercise must Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritai Status XIX Navar Married 2 Married 1 ☐ Yas 2 ☐ No if Yas, Giva XX Yaar or Datas: 1 Yas 2 No Specify: by Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacedent's Education (Spacify only highast grada complated) 16a. Decedant's Usuai Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) 12 th LABORER various trades

4300

1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Place of injury - At homa, farm, streal, factory, office building, atc. (Specify)

28b. Tima of

28a. Data of injury (Month, Day Year)

Johns 32. Registrar's Signeture

30. Nama and address of person who completed ceusa of daath (item 23a) (Type, Print)

Physician /Medical

permit. Peges Department of Important: If it any injury or c

Be 2 17. Fathar's Nama (First, Middla, Last)

LEON HARRIS

ANNA M. KENNAR- mother

19a. informent's Neme/Raiationship (Type, Print)

Examiner

Box 68760.

Division of Vital Records, P.O.

Examiner **Physician/Medicai** by Completed Be P Certification:

ledical

State Registrar Р

25. Was casa raterred to medical axaminar?

5 Pending invastigation

6 Could not be determined

176 elst

1 Yas 2 No

27. Mennar of Breath

1 DNatural

2 Accident

3 Cl Suicide

29e. Certifiar

4 Homicide

(Check only one)

29b. Signature and titla of certific

attending physician a for use as the buralsigned by the a that the de s certificate has b or Attending Physician: this efter death. Director: Af 6 24 hours efter Funeral Dire letely filled in b Hospitai To the To the To the

20a. Malhod of Disposition X X Burlai 2 □ Cramation 4 □ Donation 5 □ Other (5		20b. Placa of Disposition (Nama of camatary, cramatory or other place) ARBUTUS MEMORIAL	Data	ta 20c. Location - City or Town, Stata X 12-1-97 ARBUTUS, M			
21. Signature of Funaral Sarvice	Licensee	22. Nama and Addrass of Facility MARCH FH43					
Part1. Entar tha disease, e shock, or heart failura. Lis	complications that caused to tonly one cause on each line	tha death. Do not anter tha moda of dying, such as card a.	iac or raspiratory an	rast,	Approximata Interval Batween Onsat and Death		
Immediata Cause (Finei disaasa or condition rasulting in daath)		Dua to (or as a consequence of):	-115-		5 MIN		
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disaase or injury that initieted events		Dua to (or as a consequance of):			1		
thet initiated evants arasulting in daath) Last	d	rua to (or as a consequanca of):					
	ons contributing to death but	not resulting in the underlying cause given in Part I.			to the cause of death? Probably 4 @ Onknown		

28c. injury at Work?

1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, dete end place, end due to the causa(s) and mannar as steted.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

1 Yas 2 No

18. Mother's Nema (First, Middle, Maiden Sumama)

MOUZONE

24a. Was an autopsy performed?

26. Piaca of Death (Check only ona)

1 Yas 2 No

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Hospice

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how injury occurred

But NID

AVENUE, BALTIMORE, MD#15

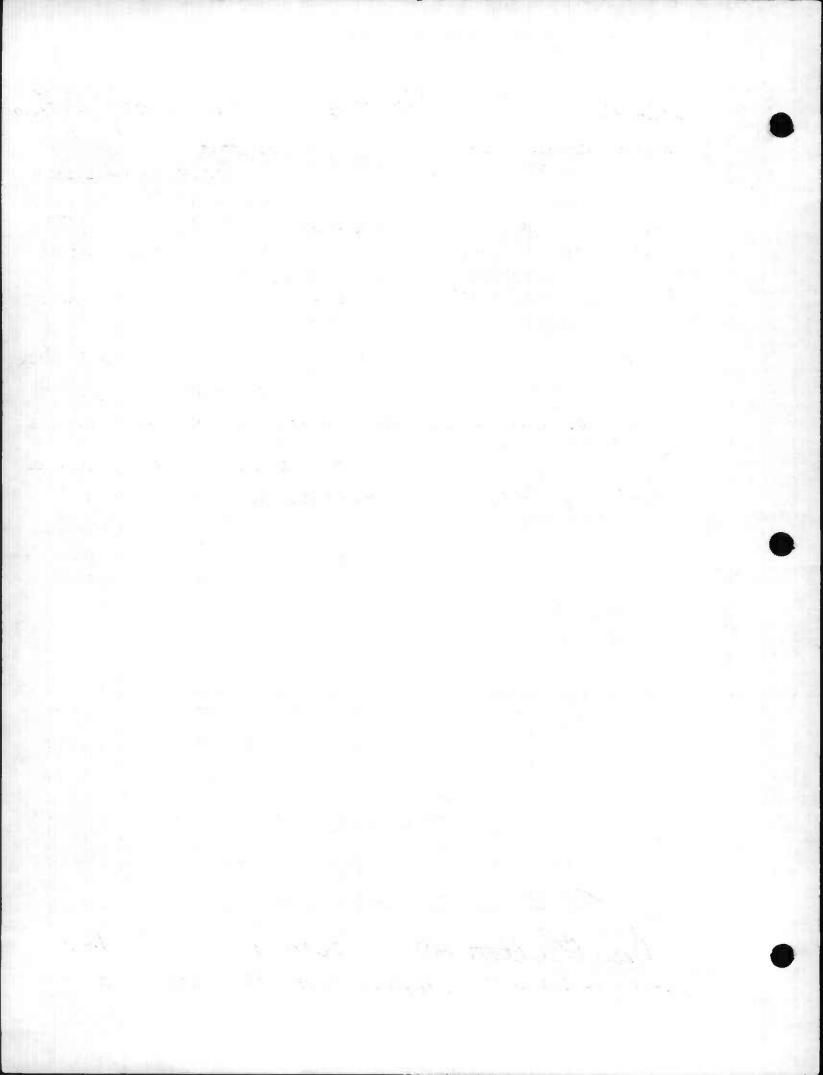
24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

ANNA

FERNHILL

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygier 35962

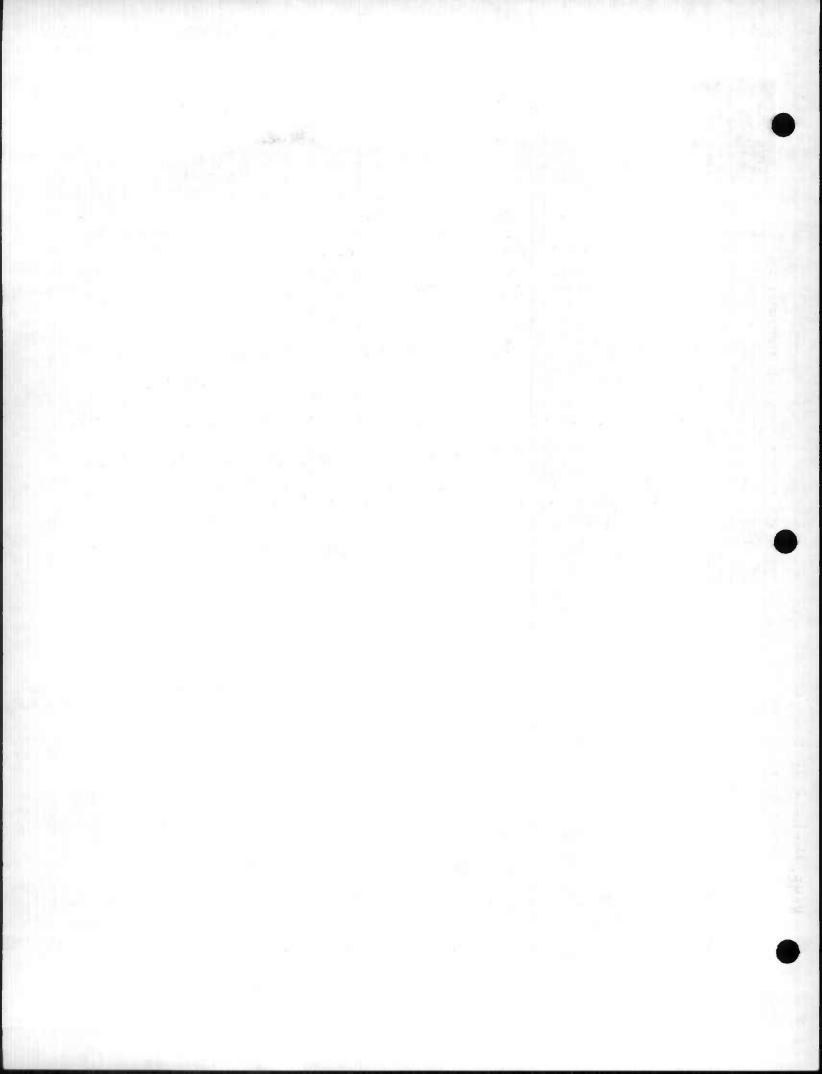
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** Month Yaer HERBERT L. HARRIS NOVEMBER 26 10:07 AM 1997 /Medical 4e. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth May 15, 1924 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F Deys 219-20-9136 73 Yrs Director Usuel Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryler Department of Health and Mental Hygiene. Important: If tien 27 is arrived other than "naturel; or flems 23a or 28a-f show any injury or other traumatic event, its Maries Engines must be notified as MD NA BALTIMORE 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4716 MELBOURNE ROAD 21229 USA Funeral Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, White, etc. 11 Yes 2 No 4-28-43 If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 by Specify: BLACK 3 Widowed 4 Divorcad Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) N A Elementery/Secondary (0-12) 12th ELECTRONIC TECHNICIAN WESTINGHOUSE 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) LINWOOD HARRIS FLORENCE MEEKINS 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH HARRIS-WIFE 4716 MELBOURNE ROAD BALTO., MD 21229 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST VET. CEM 12-3-97 OWINGS MILLS, MD of Funeral Servica Ligensee 22. Name end Address of Fecility
MARCH FUNERAL HOME-WEST tarris WZ 4300 WABASH AVE. BALTO. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ck, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Causa (Final diseese or condition rasulting in daath) my ocardial infarction 1/2 hour Examiner physician and s the burial-tran Saquentially list conditions, if eny, laading to immediate cause. Enter Underlying Cousa (Disaasa or Injury thet initieted evants resulting in death) Lest Due to (or es e consequance of): Box 68760 Physician/Medical Due to (or es e consequança of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 TYes 2 No 3 □ Probably 4 □ Unknown Records, by 24e. Wes an autopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed peen hes 1 ☐ Yes 2 PNo t ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. funeral director, 25. Wes casa raferred to medical exeminar?
1 ₱ Yes 2 □ No Be 26. Pieca of Death (Check only one) Hospitei: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) Certification: To this 28a. Dete of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturel 5 Pending 1 ☐ Yas 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 2 Accidant 6 Could not be determined 3 Sulcide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta end piece, end dua to tha causa(s) and mannar as stetad.

Medical Examinar: On the bests of exemination end/or investigation, in my opinion, daeth occurred et the time, date end place, and due to the cause(s) end manner steted. 29a. Certifier Medical 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) ldman, M.D D20676 November 26, 1997 30. Nema end address of person who complated cause of deeth (Item 23e) (Type, Print) 900 Caton Avenue Baltimore, Maryland St Agres Hospital Feldman Isadore 32. Registrar's Signeture 31. Dete filed (Month, Day, Year)

La Davidson-Rando 12.

Registrar

NAME: Herbert



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth BERNICE A. HOWE Month **Physician** 1.05 roy, 26,1997 /Medical 4e. Fecility Neme (If not Institution, give street and num 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** HOME HOSPITAL
6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year Months Deys N/A BALTIMORE 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 9. Birthplece (State or Foreign Country)
BALTIMORE **Funeral** 90 Yrs. 213-12-8176 Director AUG. 31, 1907 Usual Residence of Decedent MD 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryla or 28a-f sho Director 1 Nes 2 No BALTIMORE MD na 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 238 UNITED STATES 21229 Funeral 756 LINNARD STREET KNOLKY TO PHYSICIAN Beath Hems 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ ☒o "natural", or BLACK 1 ☐ Yes 2 ☐ X Specify: Specify. by 3 Nidowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry MEMORIAL than UNION Elementery/Secondery (0-12) College (1-4or 5+) MAID 12th HOSPITAL other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be an Venta is marked MATTHEWS BANKS EURITH 2 ALFRED BANKS 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) apple (a) STREET, BALTIMORE, MD LUCAS-DAUG. 756 LINNARD JOAN 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other piece) X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete GARRISON FOREST 12-2-97 OWINGS MILLS, VA 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signeture of Funerel Service Licansee 22. Name end Address of Fecllity WM. C. MARCH FH.-4300 WABASH AVE. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or hear feilure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in deeth) e. CERRBRAL ANOXA

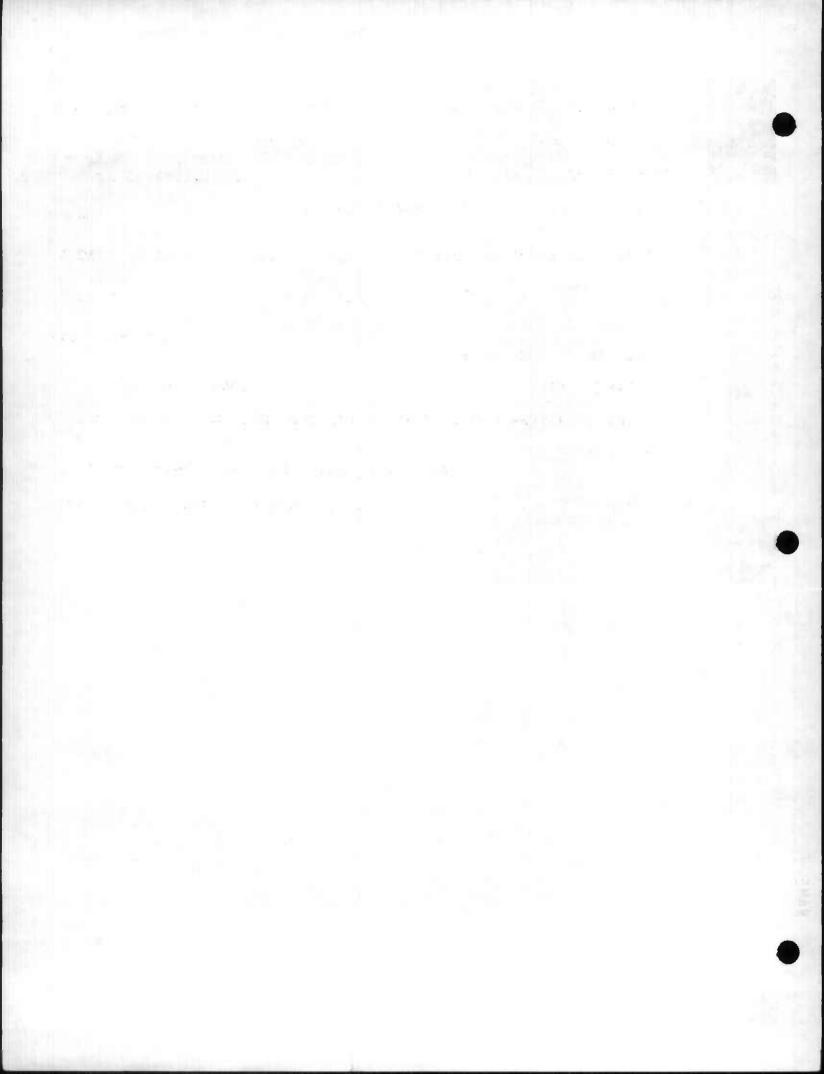
Due to (or es e consequence of): /Medical Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in death) Lest attending physician and for use as the bunal-tran certificate be execut 68760, Physician/Medical Due to (or es e consequença of): The law requires that the death P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the s should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown A1 (00 Records, þ 24b. Were eutopsy findings evellable prior to completion of cause of death? Completed 24e. Wes en eutopsy is certificate has director, page 2: 1□ Yes 2 No 1 Yes 2 No Division of Vital Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Aus after death.
Areal Director: After this ce
dy filled in by the funeral dir Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? Certification: 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pieca, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. edicai (Check only \$ 5 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) werm no 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A-P-NALEMI, M-D. CHURLH HOSPITAL BACTMO. 31. Dete filed (Month, Day, Year) 62, Registrer's Signeture State DEC 0 1 1997 whi Davidson-Randall Registrar

DHMH 16 Rev 6/95

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Deeth **Physician** Month HOLCOMBE FAIRLEAN E. /Medical NOVEMBER 22, 1997 1740 4e. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** SAINT AGNES HOSPITAL BALTIMORE If Undar 24 Hrs. Hours Min. If Undar 1 Yaar 7. Aga (In yrs. last birthday) 5. Social Security Number 6. Sax 8. Data of Birth (Month, Day, Yaar) Birthplace (State or Foreign Country) 10 M 20 F Months Deys Yrs. 69 220-24-0053 SEPT.15,1928 MD Usual Rasidance of Dacedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MD na Director Yes 2 No 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 21229 STATES 3616 W. LEXINGTON ST., BALTIMORE, UNITED Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanto Origin? (Specify Yas or Notif Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 11. Marital Status 1 Navar Married 2 ☐ Married 1 Yas 2 XNX If Yas, Giva Year or Detas: 1 ☐ Yas X X No Specify: þ BLACK Specify: 3€Widowad 4 Divorcad Completed 15. Dacedant's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry BALTIMORE CITY Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 SECRETARY th 4 years 17. Fathar's Name (First, Middle, Last) 18. Mother's Nema (First, Middla, Maidan Sumame) FRANK CAPLE LOLA PLEASANT 19a. Informant's Name/Retationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) TRACEY JETER- DAUG. 3616 LEXINGTON ST., BALTIMORE, MD21229 20e. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 284rM 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL CEM. 12-1-97 BALTO., MD 21. Signature of Funeral Service Licensee WM • C • MARCH FH • -4300 WM • C • MARCH FH • -4300 shock, or heart failure. List only one cause on each line. WABASH Approximate Interval Batween Onsat and Death Physician /Medical mediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE years disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequance of) hat initiated events esulting in death) Last Dua to (or as e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDENT Completed by PEPTIC ULCER DISEASE 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Yas 2 No 25. Wes casa raferred to medicat axaminer?
1 ☐ Yas 2 ☐ No Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Waturel 5 Panding death. 1 ∏ Yes 2 □ No invastigation 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Spacify) 4 Homicide 24 hours e 1 Certifying Phyalcien: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta end place, and due to the causa(s) and mannar stated. 29a. Certifiar within 24 hor To the Fune completely fi (Check only one) 29b. Signatura and titte of certifier 29d. Data signed (Month, Day, Yaar) ER ATTENDING Mg. NOVEMBER 22, 1997 30. Name and eddrass of person who completed causa of deeth (Itam 23a) (Type, Print) ND. WENELISA NAVARRO 900 CATON AVE. BALTIMORE, MARYLAND 21229 31. Data filad (Month, Day, Year) 32. Registrar's Signatura Die Paydson-Pandell DEC 0 1 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35965 Certificate of Death Reg. Nor 3. Time of Deeth 1. Decedent's Neme /First. Middle: Last 2. Dete of Deeth Month Dev Year 0:05 Physician MYRTLE W. NOVEMBER 23,97 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BALTIMORE CO towson) CENTER HOSPICE GILCREST If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) MAY 7, 1923 9. Birthpiece (State or Foreign 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 MXXX F Deys Hours RICHMOND, VA Director 212-22-2410 Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at BALTIMORE na MD XX Yes 2 No Director 10g. Citizen of Whet Country?
INTTED STATES 10e. Street and Number 10f. Zlp Code UNITED 21207 5222 PEMBROKE AVENUE Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Maritai Status 72 hours after 1 Never Married XX Married Yes, GNe Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Ne Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced BLACK Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health end Mantal Hygiene. nt: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) in home HOUSEWIFE- HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Be HAYES JESSIE 2 ALLEN HENDERICKS, SR. JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) BALTIMORE, MD AVENUE, 5222 PEMBROKE HALL- HUSBAND other 1 LOUIS 20b. Pieca of Disposition (Neme of 20c. Location - City or Town, Stata 20e. Method of Disposition cametery, cremetory or other pleca) Nuriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 0 permit. Page Department of Important: If any Injury or anse. ARBUTUS MEMORIAL PARK 11-28 ARBUTUS, MD 21. Signature of Funeral Servica Licensee 22. Name end Address of Fecility AVENUE MARCH FH.-4300 WABASH Pert 1. Enter the disease, accomplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete intervei Between Onset end Deeth **Physician** renal cell CARCINOMA /Medical 6 month immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician and s the bunal-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): Box 68760 8 Physician/Medical Due to (or es e consequenca of) Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco uss contribute to the cause of death? detached been signed by the should be detached 3 Probably 4 Unknown 1 Yas 2 No py Division of Vital Records, 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No director Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Date of injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident aftar death 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Mospital 24 hours a Funeral C edical 1) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hou To the Fune complately fi 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title-of certifie , uno 1 God deeth (Item 23a) (Type, Print). Charles J. Balto. Md 21204 31. Dete filed (Month, Dey/Year) 32 Registrer's Signeture

Kia Davidson-Randell

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Registrar DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Dey 27,1997 **Physician** RA MON EDWARD HELFRICH NOVEMBER 01:30PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner EMER Room HOSPITAL MARUS LEONARD TO WA ST. WHRY If Undar 1 Year | If Under 24 Hrs. | 8. Dela of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 1 M 2 F 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 219-26-2260 60 Yrs Director Sept 22 1937 MD Usual Rasidenca of Dacadani 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show Examiner mant be notified at Director St. Mary's MD 1 Yes 2 No Mechanicville 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 6 41389 Delabrooke Нете 23а 20659 USA Funeral 12. Was Dacedent Ever in U,S. Armad Forcas? 1 23 Yas 2 □ No If Yas, Giva Yaar or Datas: 61-63 Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 11. Meritel Status 14. Rece - Amarican Indlen, 72 hours after Biack, Whila, atc. 1 Navar Marriad 2 Married altimore, Maryland 21215-0020 naturel', or 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedant's Education (Specify only highast grade completed) 18e. Decedant's Usuel Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantery/Secondary (0-12) Collaga (1-4or 5+) 12 Machinist Western Electric 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Be Peges 1 and 2 should be nent of Health and Mental Si McAllister ပ Mildred Helfrich 19a. Informent's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) important: If itam 27 is any injury or other trau / wife Alice Helfrich Mechanicville, MD 20659 41389 Delabrooke 20a. Mathod of Disposition 20b. Pleca of Disposition (Nama of cematery, cramatory or other plece) Dec 3 20c. Location - City or Town, Steta 1 X Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Spacify) Garrison Forest Vet. 1997 Owings Mills, MD 22. Nama end Addrass of Facility Connelly Funeral Home of Dundalk Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediata Ceusa (Final disaasa or condition rasulting in death) /Medical ASYSTOCE Examiner Examiner CARDIO FOLMWARY ARRES

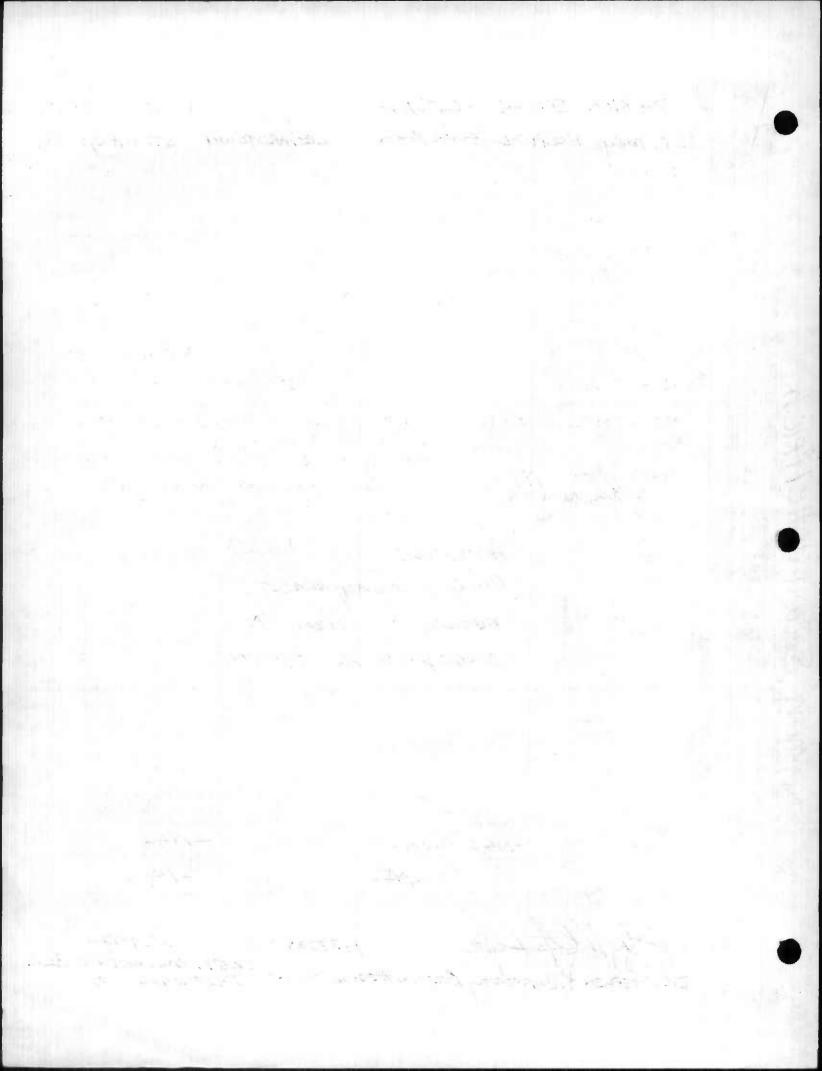
Due to (or as a consaquance of): Sequentielly list conditions, if any, leading to Immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last METASTIC Physician/Medical Due to (or as a consequence of): CEREBRO HAS CULAR Pol Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? The law requires that the á 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by page 2 should be Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yas 2 No this certificate 1 ☐ Yas 2 ☐ No of Vital Physician: Be 25. Was case rafarred to medical 26. Placa of Daath (Check only ona) axaminar? Hospitel: 1 ☐ Inpatiant 2 1 Yes 2 No Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? After Division Attending 1 Natural 5 Panding Invastigation Injury 1 Yes 2 ₽No IYA--NA-2 Accident birector: - M -6 Could not be datarmined 3 Suicida 28e. Place of Injury - At homa, farm, straet, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 6 Hospital 6 124 hours 1 Certifying Physician: To the bast of my knowledge, death occurred et the time, data and place, and due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medicai To the To the I 29c. License number 29d. Deta signed (Month, Day, Year) 1437228 MD s of person who completed cause of deeth (Item 23a) (Type, Print) 22576 MACARTHUR BLUD CARERRA BRETON WEDLEX GREEP DR. STEPHEN 31. Data filed (Month, Day, Year) 32. Ragistrar's Signature State

relia Davidson-Randall

DHMH 16 Rev 6/95

Registrar

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29d. Dete signed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

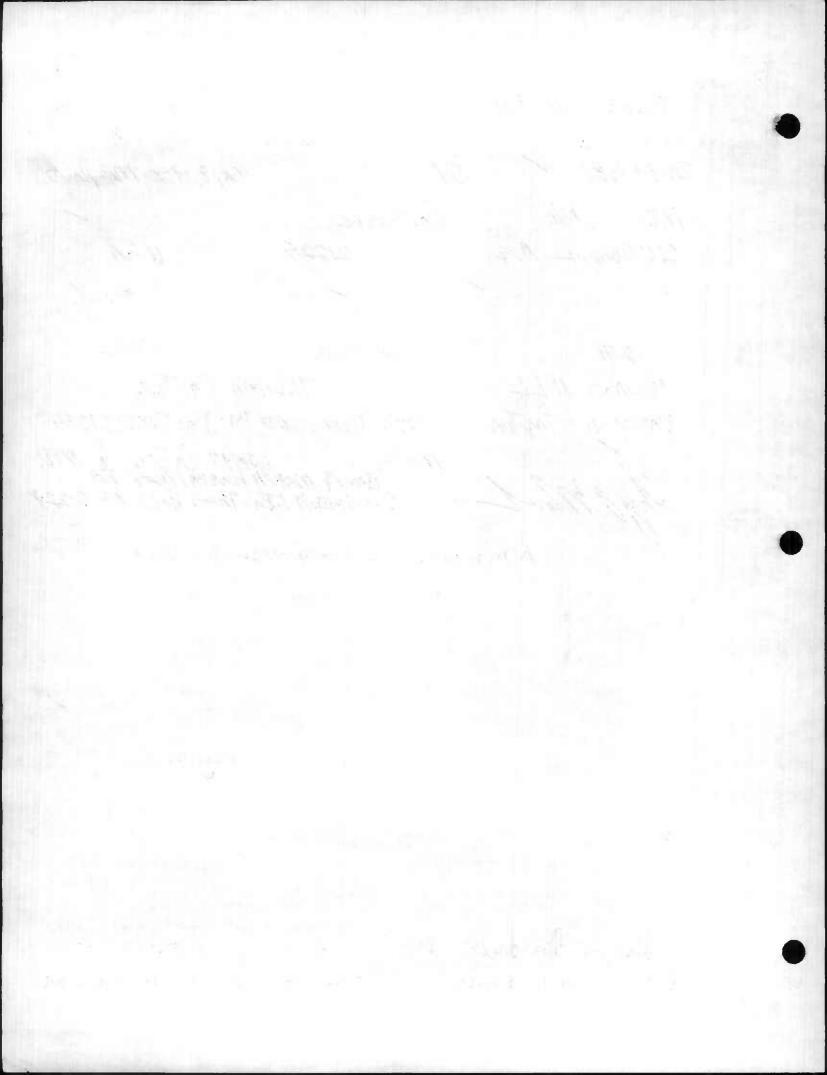
NOVEMBER 21,1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YAWDOWN
31. Data filed (Month, Dey, Year)

CONELC 32. Registrar's Signatura

State Registrar



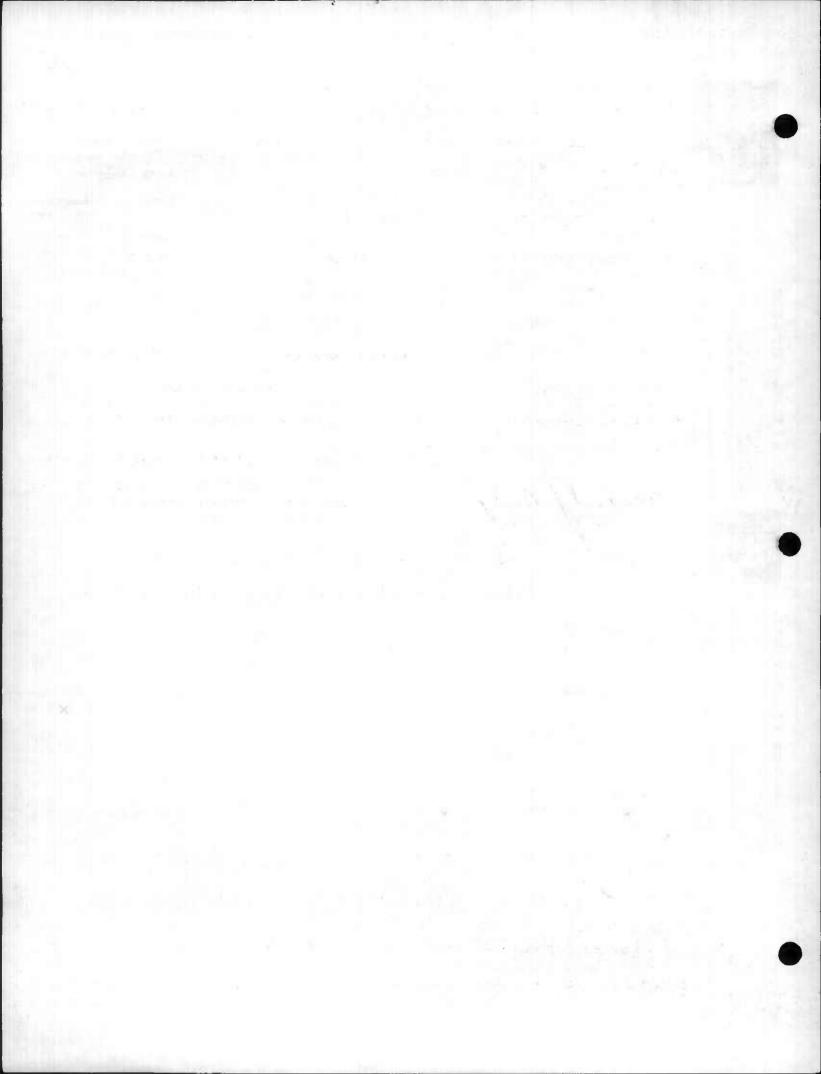
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant'a Nama (First, Middla, Last) 3. files of Courth 2. Data of Death **Physician** Month RAY MOND 1327 J. HARRINGTON Nav /Medical 25 1997 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Howard County General Hospital Columbia Howard County If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) if Undar 24 Hrs. Birthplaca (Stata or Foreign Country) **Funeral** 8. Data of Birth (Month, Day, Year) Days 220-20-3177 Months Hours Director 70 Sept. 27,1927 Maryland Usual Rasidance of Dacedant death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Insida City Limita Director Md. Howard Co. Ellicott City 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3023 Hickorymede Drive 21042 Funeral U.S.A. 12. Was Decedant Evar in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 Navar Marriad 2 Married Yas 2□No 1944-21215-0020 1 ☐ Yas 2 ☐ No Specify: Completed by Specify 3 Widowed 4 Divorced Yaar or Datas: 1946 White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Service Mechanic Office Supplies permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Itam 27 is marked other any injury or other traumatic event, Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 16. Mothar's Nama (First, Middle, Maiden Surnama) Be Raymond Harrington Rosamond A. Carter 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Mary A. Harrington/Wife 3023 Hickorymede Dr. Ellicott City, Md. 21042 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacity) 11/28/97 Parkville, Maryland Parkwood Cemetery 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. Luck Towson, Maryland 21204 1050 York Road 23a. Part1. Entar tha disaasa shock, or haart tailura. complications that curied the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on such line. Approximata Interval Batween Onsat and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in daath) /Medical cardiac arrhythmia Examiner cordiovascular dispose Atherosclerotic The law requires that the death certificate be executed burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last and Dua to (or as a consequence of): Box 68760, physician Physician/Medical the Dua to (or as a consequance of): USB signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown by 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed has certificate 2 No 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: funeral director, 25. Was casa ratarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 2 No 1 Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 26d. Dascribe how injury occurred After 5 Panding invastigation 1. Natural after death Director: / 2 Accidant 1 Yas 2 No the 3 Suicida 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) filled in by 4 Homicida 0 24 hours a Hospital 12 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian within 24 ho To the Fune completely fi (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Data signad (Month, Day, Yaar) Ruch mD D 25004 NOU 25, 1997 CLEDELO

State Registrar

HOWARD COGENERAL HOSP, COLUMBIA, MD 21045 Julia Davidson-Randeste 31. Data tilad (Month, Day, Year) 32. Radstrars Signature DEC 0 1 1997

30. Nama and addrass ot person who complated causa of death (Itam 23a) (Type, Print)

LEVAN KUCK



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 23,1997 7:00p.m. SOK KUM HWANG November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium
It Under 24 Hrs.
Hours Min.
Aug. 20, 1933 Stella Maris Hospice Baltimore Co. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 15 M 2□ F 212-80-4258 64 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 Toyes 2 T No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 North Kenwood Ave. 21224-1241 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Datas; 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Korean þ 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Dry Dock 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill h end Mental H is marked oth Be 2 Do Hak Hwang Soo Dong Jo 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Department of Haalth end important: if Item 27 is m any injury or other traum Elyse Hwand (Daughter) 30 North Kenwood Ave. Baltimore, Maryland 21224-1241 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lakemont Memorial Park 11/29/97 Davidsonville, Maryland 21. Signature of Funeral Sarvice Licensen L. Gair 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. air 1050 York Rd. Towson, Md. 21204 0 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa or each line. Approximata Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disaasa or condition resulting In daath) a Cerebral Pontine Myelinolysis Examiner Due to (or as a consequenca of) Examiner physician and the burial-transit Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting In death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequenca of): esn signed by the al Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco was contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen hes pega 2 certificate 1 Yes 20 No 1 Yas 2 No 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending P eftar deeth. Director: After 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homiclde within 24 hours e To the Funeral C Hospital 29a. Certifier 1🔏 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated Medical 2 Msdlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated. the 29b. Signature of stie of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-24-97

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

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State Registrar 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

EDWARDS

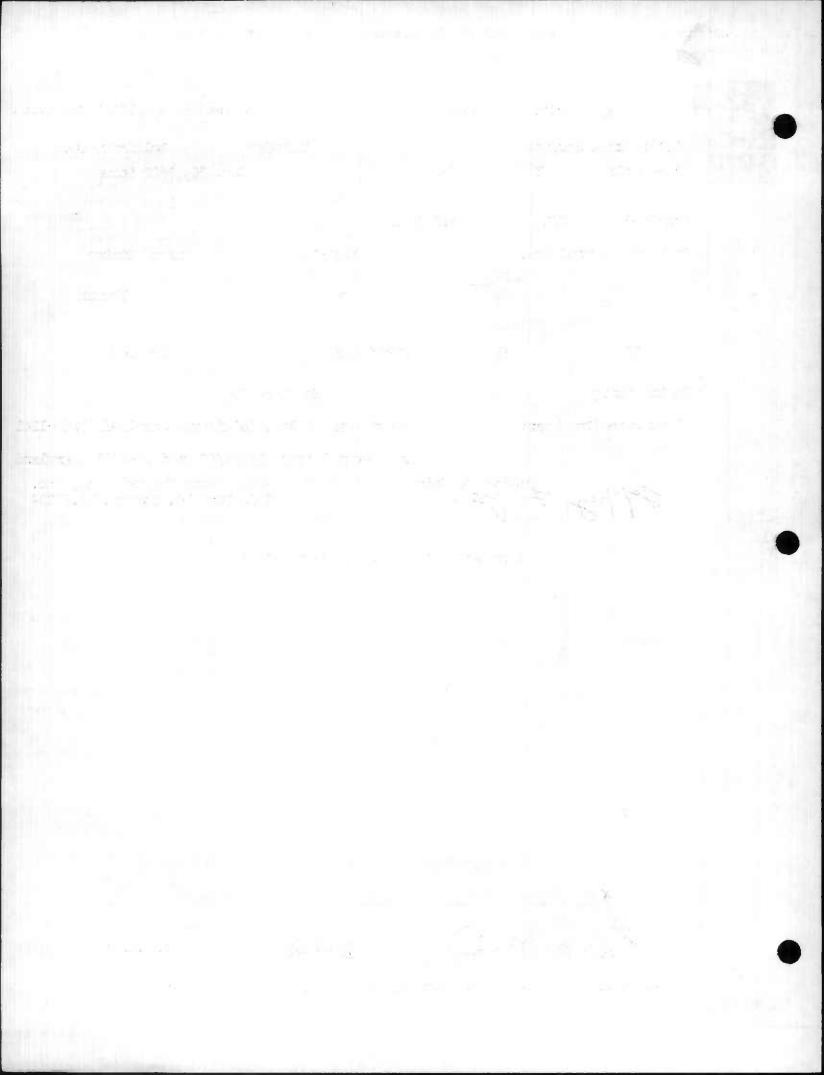
32. Registra's Signature

Fuha Davidson

DR. PENELOPE

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

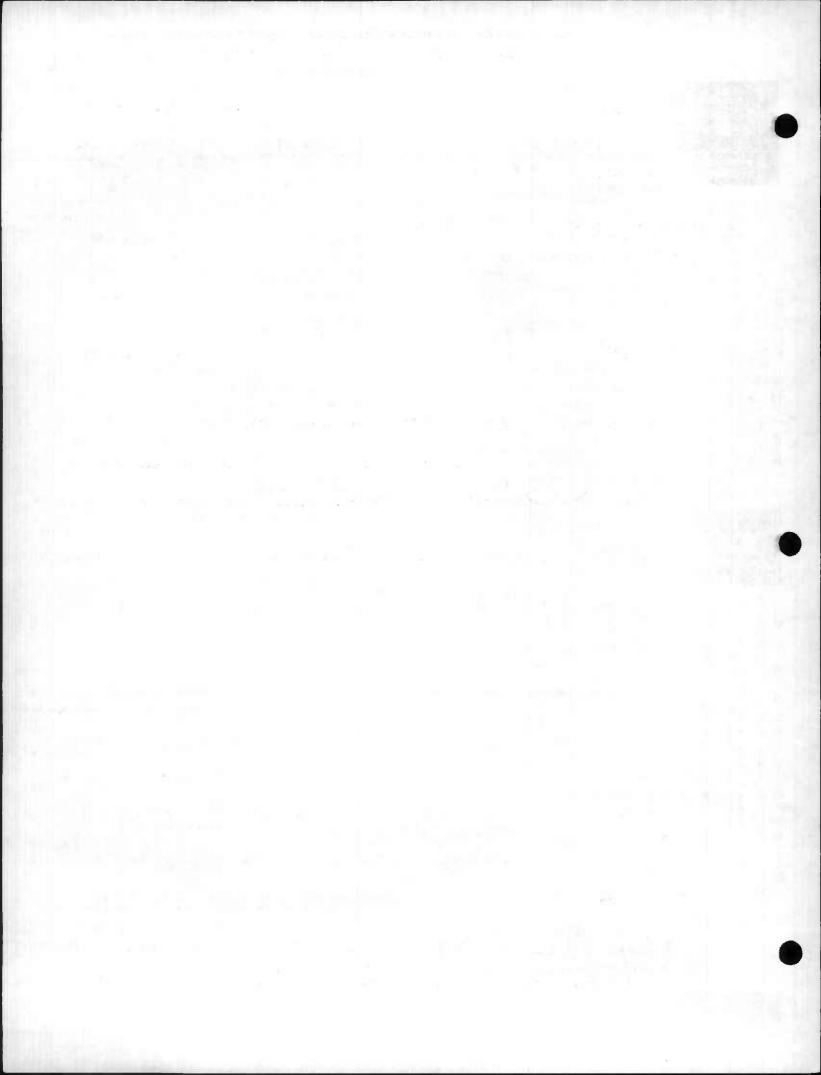


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death November **Physician** 27, 1997 Elma Virginia Heishman 10:10 a.m. /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health Care Prince George Laurel 5. Sociel Security Number 7. Age (In vrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min 84 Yrs. 9, Director 215-18-6954 Dec. 1912 Maryland Usual Residence of Decedant death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 7080 Cradlerock Way, Apt. 212 21045 USA Funeral 12. Was Decedent Ever In U,S. Armed Forcas?
1 ☐ Yas 2 ☑ No If Yas, Give Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien Black, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No White Specify: by 3 X Widowed 4 Divorcad Yaar or Datas: Be Completed 15. Decedant's Education (Specify only highast grade complated) 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamentary/Secondary (0-12) Collage (1-4or 5+) 12 0 Self Employed Beautician 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) William Lilley Laura Adron 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Charles M. Heishman / Son 15734 Union Chapel Road, Woodbine, Maryland 21797 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 💢 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Savage Cemetery 11/29 Savage, Maryland 21. Signature of Funarai Sarvice Licenses 22. Nama end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intervel Batween Onset end Death **Physician** Immediate Ceuse (Finel diseasa or condition resulting in daath) /Medical Cerebro vascular 2 weeks Examiner Dua to (or as e consequanca of) Examiner tension The law requires that the death certificete be executed attending physician and for use as the buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in deeth) Last Due to (or es a consequança of). P.O. Box 68760, Physician/Medical Due to (or as a consequence of) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy After this certificate has 1 Yes 2 No 1 ☐ Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours eiter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was casa rafarrad to medical axaminar? 28. Placa of Death (Check only one) Other: Am Nursing Homa 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Deeth Certification: 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Natural 5 Pending invastigation Injury 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 Homicida Medical 29a, Cartifiar 1 Certifying Physician: To tha best of my knowledga, death occurred at tha time, date end plece, and dua to the causa(s) and mannar as stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end plece, and dua to the cause(s) and mannar stated. 29b. Signatura and Itia of certifian 29c, License number 29d. Data signed (Month, Day, Year) D50607 1997 November 30. Name end ad ress of person who complated cause of deeth (Item 23a) (Type, Print) 720 Maider Choice lane Catonsville Gamil Wafer 31. Date filad (Month, Day, Year) 39 Registrar's Signature State Jund/o/ Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day RUTH HEBBER NOUTMBER 27, 1997 5:45 pm 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth JOHNS HOPLINS HOSPITAL BALTIMURELATY If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 2 PF Yrs. 219-16-4854 June 13, 1923 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 THES 2 No BALTIMORE, CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? FAYETTE, ST. U.S.A. 2516 E. 71234 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Wes Decedent of HIspenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritei Status 14. Race - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 NHO Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WETZLERS. Co SALES PErson 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumame) STEPHAN DUHAN - J. MYRTLE WILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 W. WOODWELL RD. BALT, MD 21332 GANGE -015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Surial 2 ☐ Cremetion 3 ☐ Removei from State 12/1/97 4 ☐ Donation 5 ☐ Other (Specify) cometery. BALT, MD GAKLAUN 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Hartley Willer Funeral Willer 7527 HASFORD RD BALT, MD 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCAROIAL INFARCTION 8 HOURS disease or condition resulting in death) Due to (or es a consequence of): WEDNARY ARTERY DISENSE 10 YEARS Due to (or as a consequence of) PERIPHERAL VASCULAR DISEASE 10 Ymas Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Types 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? 1□ Yes 2 No 1 Yes

Physiclan /Medicai Examiner

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signed by the el

that the death certificete be executed

Box 68760

P.O.

Records.

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Division

Physician/Medicai Examiner

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Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

10a. State

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

by

Be Completed

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Hygiene.

. nt of Health e

permit. Page Depertment of Important: If any injury or once.

Pages 1 and 2 should be nent of Health end Mentel

death

filed within 72 hours efter

altimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

MYPERTENSION

25. Was case referred to medical examiner? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28d. Deacribe how injury occurred

26. Place of Death (Check only one)

27. Manner of Deeth 1 Netural 2 Accident 5 Pending investigation 3 ☐ Suicide 6 Could not be determined

28h Time of 28e. Dete of injury (Month, Day Year) 28c. injury at Work?

1 ☐ Yea 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, deem occurred at the time, date and piece, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and menner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

lise

KES-000

NOVEMBER 27, 1997

30. Name end eddress of person who completed ceuse of death (item 23e) (Type, Print) MELISSA

TURNICE

Hospitai:

615 NORTH WOLFEST JOHNS HOPKINS HUSPITAL, TOWER 110, BALTIMULE, MO 21205

State Registrar

31. Dete filed (Month, Day, Year)

32. Registrar's Signeture I Julie Davidson-Randell

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the Hoopital or Attending Physician: within 24 hours after feeth.

To the Funeral Disector: After this certific completely filled in by the funeral director,

45 50 45 6 The fifth of the best of the con-Salario S STATE OF THE STATE OF and simple to a first to be first all the first to be a second or the second of the se

State of Maryland / Department of Health and Mental Hygiefie

Physician /Medical Examiner

3. Time of Death

Funeral

Director

permit. Peges 1 and 2 should be liled within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-4 show any injury or other treumatic event, the Medical Examiner must be notified at once.

Completed

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner

Physician/Medical

by

Completed

Be

Medical

sician and burial-transit physician at the burial 50 esn Po ed by the e signed by t peed hes page 2 certificate I or Attending Physician: efter death. Director: After this certifica director, luneral e Hospital or Atte 24 hours efter de e Funeral Directo detely filled in by ti

P.O. Box 68760, that the death certificate be

Division of Vital

To the Hosp within 24 ho To the Fune completely fi

Certificate of Death 1. Decedant'a Nama (First, Middla, Last) 2. Data of Death 1997 Month CHARLES FRANKLIN IRELAND, SR. 4:13 PM Nov. 22, 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 4203 Atlantic Avenue Unit #9 Ocean City Worcester If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country)
 MD . Months Days 1 M 2 F Yrs. 218-03-1668 78 May 26, 1919 Usual Rasidenca of Decedant 10a Stata 10b. Count 10c. City, Town or Location 10d. Insida City Limits Maryland Worcester Ocean City 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4203 Atlantic Avenue 21842-6402 U.S.A. Funeral 12. Was Dacedant Evar In U,S. Armed Forcas? 1X Yaa 2 □ No If Yas, Giva Yaar or Datas: WW II 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 X No White þ Specify: 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Buainaas/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Regional Sales Manager Spice Manufacturer 12 17. Fathar'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Surnama) Noah F. Ireland Grace 2 19b. Mailing Addrasa (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code 1042 -19a. Informant's Name/Ralationship (Type, Print) Mark Ireland Ellicott City, MD 3967 Ducks Foot Lane 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata Dulaney Valley Mem. Gardens 11/26/97 Timonium, MD. 4 □ Donation 5 □ Othar (Specify) 21 Shantura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. Towson, MD. 21204 1050 York Rd. 23a. Part Lonier tha disaasa, or complications that caused tha daath. Do not entar tha mode of dying, such as cardiac or respiratory arrast, or heart failure. List only one cause on each line. Approximata Interval Batw Onset and Death Immediata Cause (Final disassa or condition rasulting in daath) Iremia weeks

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diaaasa or Injury that initiated evants rasulting in daath) Last

Dua to (or as a consequenca of) Obstructive Uropathy Metastatic

Dua to (or as a consequence of Squamous Cell Carcinoma Dua to (or as a consequanca of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mokina

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 ☐ Unknown

24a. Was an autopay performed?

24b. Wera autopsy findinga available prior to completion of cause of death?

25. Was casa rafarrad to medical axaminar? 1 Yaa 2 No

1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year)

28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

26. Placa of Death (Check only ona)

2/ No

2 Accidant 3 Suicida 4 Homicide

27. Mannar of Death

1 Natural

5 Pending Invastigation 8 Could not be datarmined

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifian (Check only one)

Certifying Physician: To tha bast of my knowledge, daath occurred at tha tima, date and place, and due to the causa(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number

29b. Signatura and titla of certifiar

D36619

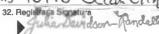
29d. Data signad (Month, Day, Year)

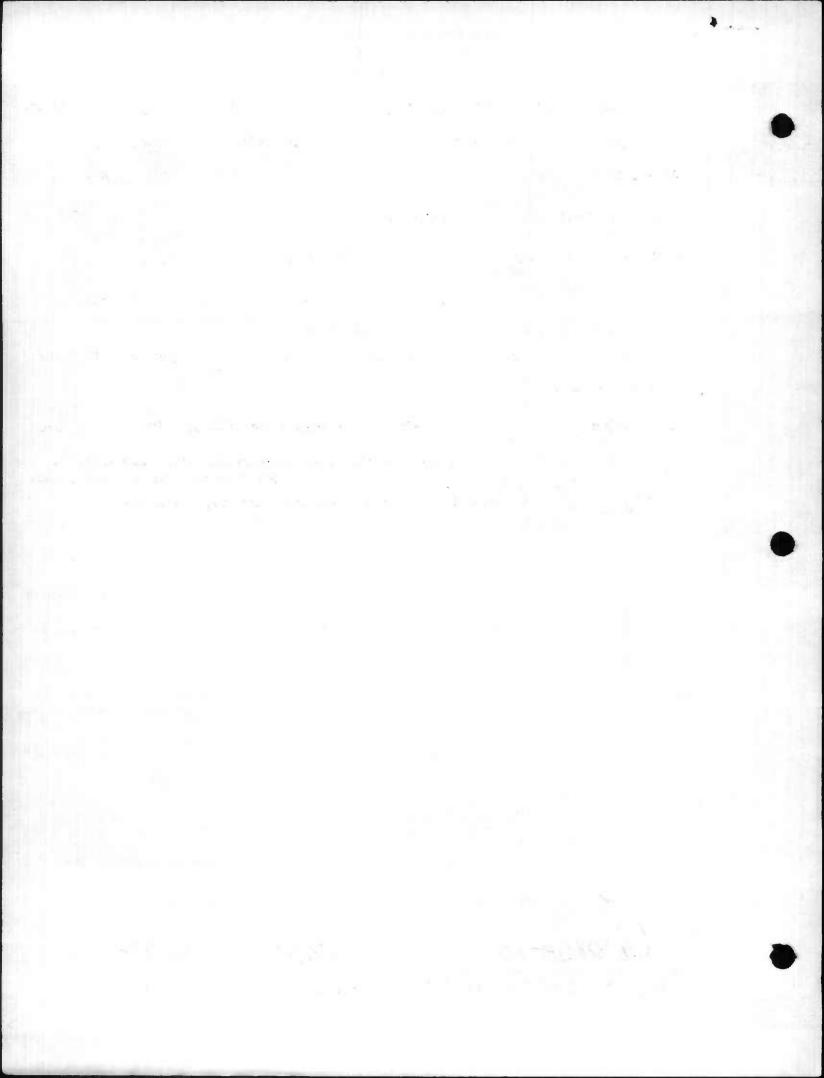
30_Name and addrasa of person who complated causa of death (Item 23a) (Type, Print)

PETER 5 ABBOTT MS 10445 Ocean City Blud Borlin Md 21811 31. Data filed (Month, Day, Year)

Registrar

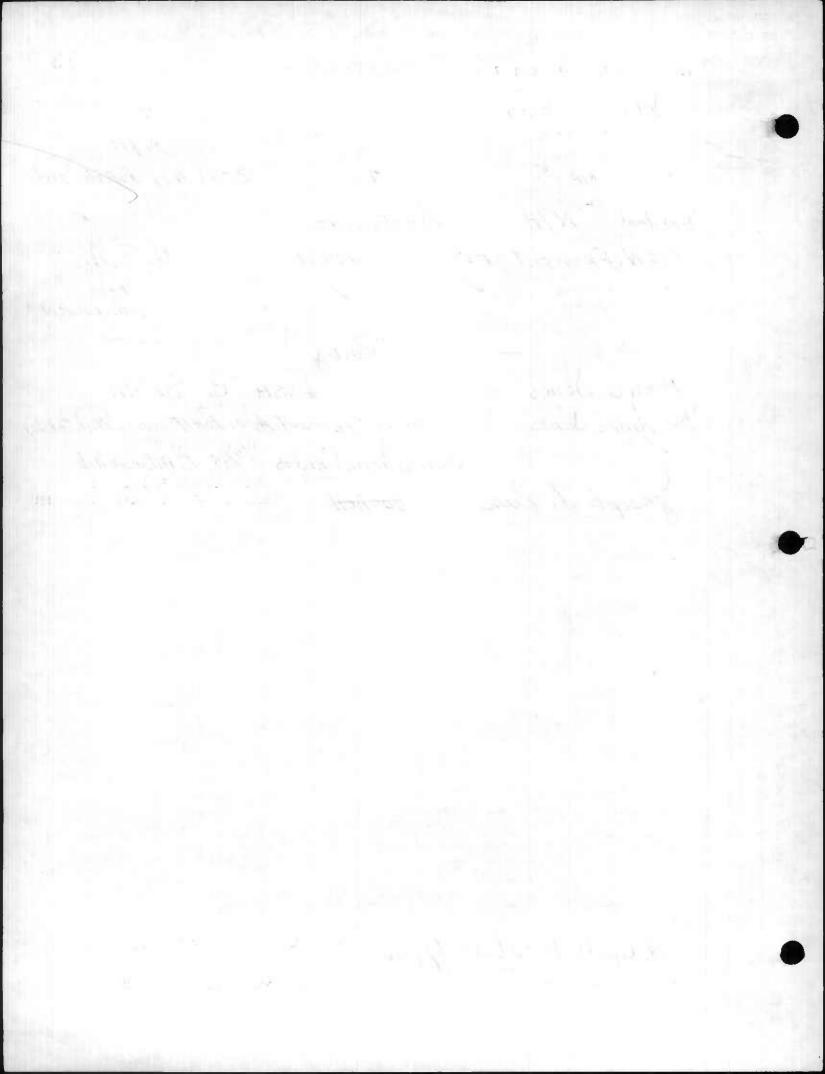
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JOHN JO	ONE	S Items:23a part I,II,2 Item: 22 per F.H. G-75	State of Ma 27,28a-f per M 4 12/1/97 reb	Pyland Department	eriment of rtificate of	Health and Death	d Mental Hy	rgiene 7	359	73		
Physic		1. Decedent's Name (First, Middle, Le					2. Date of D Month		Year	me of Death		
/Med		John	bnes			# 01 T	NOV.	19, 199		:45 PM		
Exam	iner	4a. Facility Name (If not institution, git UNIVERSITY HOS				BALTIM	or Location of Dea ORE	th 4c. County	of Death			
Funera	ī		Sex 7. Age	(In yrs. lest birthday)	If Under 1 Yea Months Days		Hrs. 8. Dete of Bi	rth ay, Year)	9. Birthplace (S	State or Foreign		
Director	8	Usual Residence of Decadent	INAM ZUF	Yrs.	7		3-2	1-1997	BAID	· md.		
how		10e. State 10b. County		10c. City, Town or Lo	cation					ide City Limits		
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ter death	Funerai	130 N; FREN	12. Was Decedent Ev	ver in U,S. 13.	Was Decedent of	Hispanic Origin	? (Specify Yes or Nuerto Rican, etc.)	o- 14. Rad	ce - American Indi	en,		
020 urs after death with alf, or itema 23a or	by Fu	1 Never Married 2 Married	Armed Forces? 1 Yes 2 Armed forces?)	1 ☐ Yes 2 12 No		uerto mican, etc.)	Specifi	ck, White, etc.			
15-0020 72 hours af natural, or		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a. Deced	dent's Usual Occu	petion			11 .00	CAN		
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Maryla d 2 should th end Men 7 la merke traumetic	F	19a. Informant's Name/Relationship		19b. Mailir	ng Addresa (Stree	et and Number of	Rural Route Numi	oer, City or Town,	State, Zip Code)			
2 0 m 2 m	1,,	Mr. Andre Jor.	es	1301		mont	Ave. B.	Allimo.	re ma	21201		
0 50 5		20a. Method of Disposition 1 Burial 2 Cremation 3 D	Removal from State	20b. Place of Dispo cemetery, cres	sition (Name of halory or other pi	page)	11/28/	20c. Location	City or Town, Sta	ate /		
Baltim permit. Pag Department important: I any injury o		4 Donation 5 Other (Specify) OShell Mem. Garokits 999 Ballimore Mu 22. Name and Address of Fecility 1995 But										
Balt permit. Depart importu any inj		JOSEPH L. RUSS FUNERAL HOME 22. Name and Address of Fechiny JOSEPH L. RUSS FUNERAL HOME 2222 W. NORTH AVE. ABLTIMORE,										
_		ant I. Enter the disease, or com hock, or heart failure. List only	pplications that caused the	he death. Do not ent	er the mode of dy				Appro	ximate		
Physician			One cause on each line							al Between and Deeth		
/Medicai Examiner		Immediete Cause (Final disease or condition resulting in death)	a. MALN	UTRITION WIT	H SEPSIS							
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and and and and and and and and and and	xaminer	Sequentially list conditions,										
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Records,	ed by							en autopsy	24b. Were aut	opsy findings		
Record law require hes been si	Completed						pen	ormed?	evailable completio of death?	n of cause		
= F # a	Com						1 🔀	Yes 2 No	XXYes	2 No		
Of Vital Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0	har	Deeth (Check only					
Phys raid	7: To	XXYes 2 No 27. Manner of Death	28e. Dete of Injury (Month, Day)	28b. Time of	3L DOA		g Home 5 Res	how injury occur				
Division or Attending efter death. Director: After	Certification:	1 □ Natural 5 □ Pending Investigation	ork? ∐Yes 2XXXINo	failed t		nourishmen	nt and					
Division Attendent effer deat Director:	rtific	2 Accident 3 Suicide 4XX Homicide 1 Investigation 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rurel Route Number, City or Town, State) 130 N. Fremount Ave.,				
Hospital c 24 hours el Funeral D etely filled I		29a, Certifier 1 Certifying Ph	home	more leaved and the state of th	4 4 4 4		Baltimore City, Md.					
Division To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	edicai		ysician: To the best of niner: On the basis of e and manner state	xamination and/or Inv						use(s)		
To the vithin 2 To the comple	Me	29b. Signeture end title of certifier	1	,		se number		-	d (Month, Day, Yo	ear)		
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(0)		30. Name end eddress of person who				D=1+4		1 - 12 0-	201			
C+	ate	Stephen Radentz, 31. Date filed (Month, Day, Year)		III Peni	street	, Baltin	nore, Mar	ytand 21	1201			
St Regist	ate	31. Date filed (Month, Day, Year)	Ban Registras	s-Signatura dAm Pandall								

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 1, per Physician G-754 12/1/97 reb 1. Decedent's Name (First, Middle, Last) , JOHN GREGORY JONES 2. Dete of Deeth **Physician** 4a. Fecility Nema (If not institution, give street and number) 4c. County of Death Will bolows /Medical 4b. City, Town, or Location of Deeth **Examiner** Rankdall's ADWA If Under 24 Hrs. 8. Dete of Birth Month Day, Yes 7. Aga (I) yrs. last birt day) S AJWA SCITCHAM

Sets of Birth

Month, Day, Year)

JUL.31,1946 BALTO., MD 5. Sociel Sacurity Number If Under 1 Yaar | If Under 24 Hrs. Dete of Birth (Month, Day, Year) **Funeral** 17 X 20 F Days Director 213-46-2800 51 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1X1Xes 2□ No (ELKRIDGE) Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b STATES UNITED 21227 PARKWAY DEEP 238 5 RUN thems 2 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Place - American Indian, Black, White, etc. Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 b army 1□ Yes 2□ No X Specify: BLACK Specify: by 3 ☐ Widowed ★ Divorced "natural", the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECURITY SOCIAL ANALYSIS PROGRAM 12 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) h and Mental I 2 MARY SAWYER JOHN ALFRED JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Itam 27 is any Injury or other trau once. ST. GEORGES, BALTIMORE, MD 21212 4522 MARY W. JONES - mother 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST VA 12-1-97 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FH.-4300 WABASH e of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 1 Yes 21360 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 3CL No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA 27. Maryner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Atter Attending Natural Accident 5 Pending investigation 1□Yes 2□No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) after A 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end manner as steted.

| Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. Medical 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

> s of person who completed ceuse of death (Item 23e) (Type, Print) varth ww 1

32. Registrer's Signeture

who Davidson-Randall

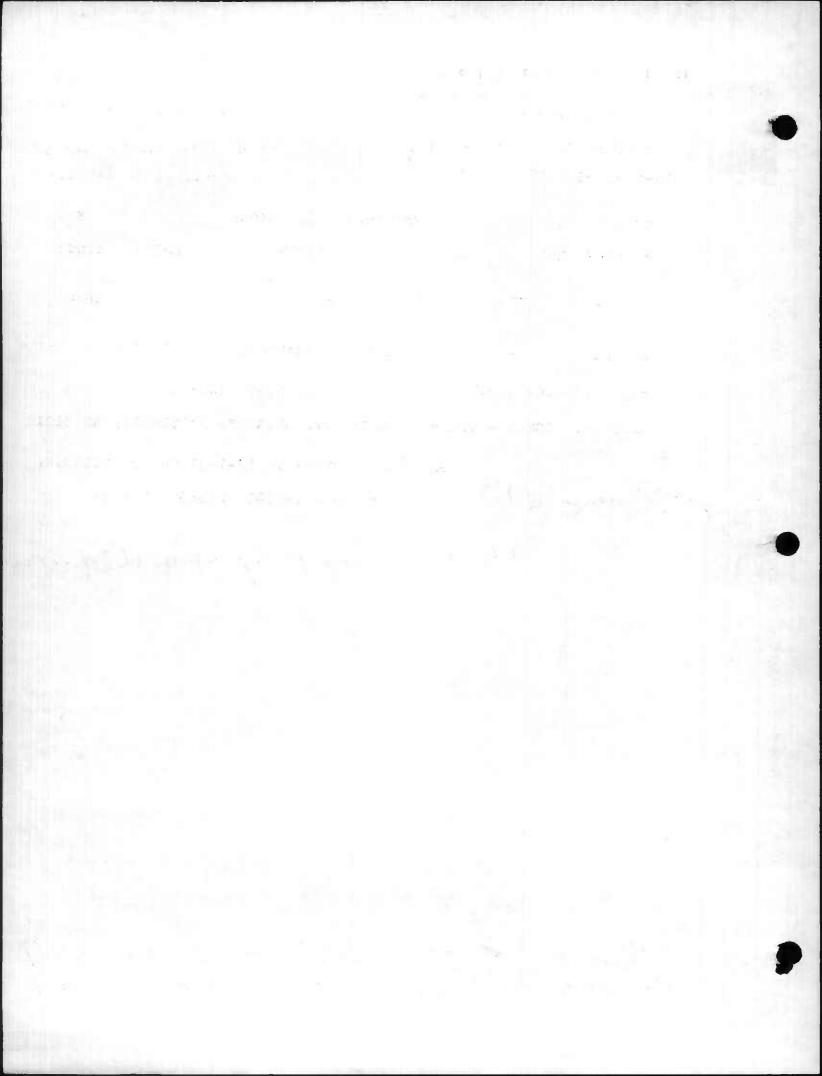
Rondalistum, ma

State

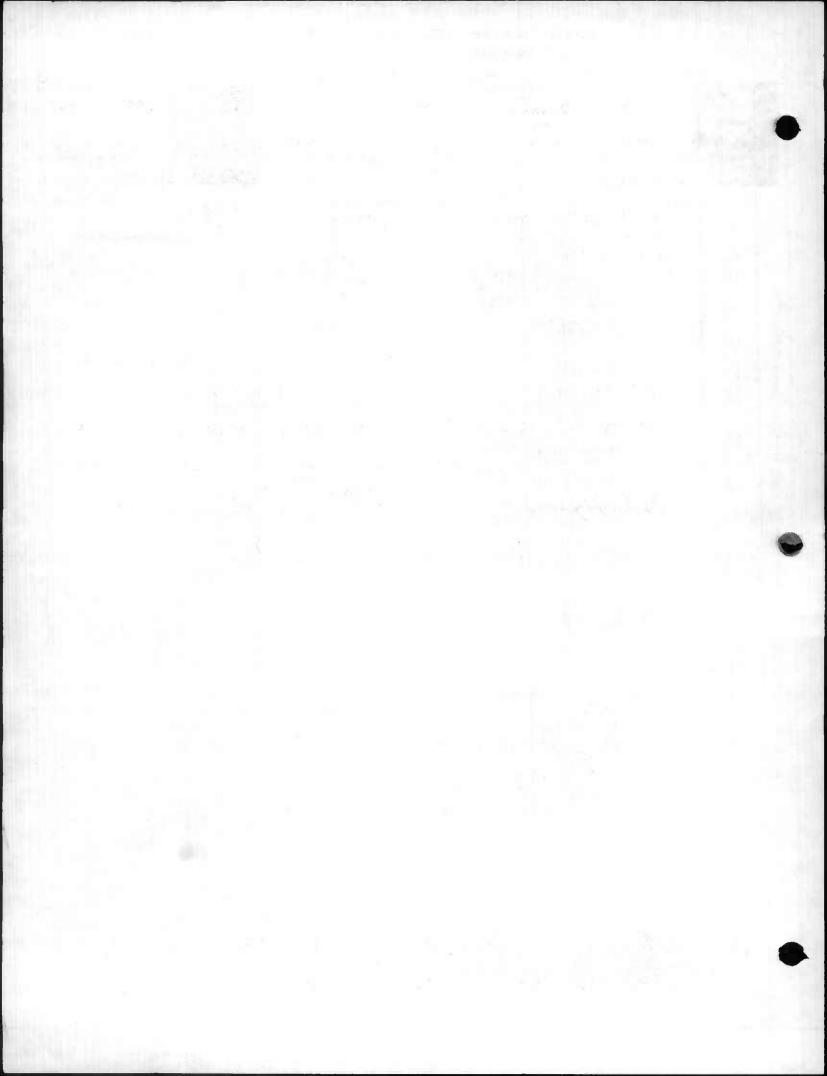
Registrar

31. Date filed (Month, Day, Year)

1997



					Certificate of			Reg. No. 9	7 :	35975		
Physic /Medi		Decedent's Name (First, Middle, Sarah D	owlin	Jones			2. Dete of De Month	_	9°7	3. Time 3 auth		
Examination Funeral Director			rement Com	munity ge (In yrs. last bird	hdey) If Under 1 Year Months Deys	4b. City, Town, or Lo Cockeysy If Under 24 Hrs. Hours Min.	*ille Baltimore County 8. Dete of Birth (Month, Day, Year) Sept 20, 1916 Pennsylvania					
Manylan H show	tor									1 ☐ Yes 27 No		
th with the 23a of 28a	al Director	10e. Street end Number 13801 York Road			10f. Zip Code)30		10g. Citizen of Whet Country?				
72 hours after death with the Maryland natural; or items 23a or 28=4 show pical Examiner must be notified	by Funeral	11. Maritei Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces	7	13. Wes Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispenic Origin? (Span, Mexicen, Puerto Specify:	ecity Yes or No- Rican, etc.)	- 14. Rac Bled	e - Americ k, White,	etc.		
within ane.	Completed	15. Decedent's (Specify only highest) Elementery/Secondery (0-12)	College (1-4015+)									
	Be C	17. Fether's Neme (First, Middle, La		111	DLALIAII	18. Mother's Neme				ation		
Mal yiallo d 2 should be file th and Mental Hy ?? is marked oth traumatic event	ToE	William Dowlin 19e. Informent's Neme/Reletionship										
baltimore, N permit. Pages 1 and 3 Department of Haalth Important: If Item 27 any injury or other tr		20e. Method of Disposition 1 Buriel 2 X Cremetion 3 4 Donetion 5 Other (Spe 21. Signeture of Funerel Service Lice	□Removel from State cify) ensee	20b. Plece of cemeter, Media	emetery ass of Fecility	11/29/9	Media,	Penn	sylvania			
Physician peak certificate be executed at the principal and attending physician and attending physician and attended as the bunal-transit	ian/Medicai Examiner	23a. Pert1. Enter the disease of occashock, or heart failure. List on Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	e. Here	Due to (or es a c	onsequence of):	1		rest,		Approximate Interval Between Onset and Deeth		
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requires been sign should be	Completed by	hype	rlipid	emia					COL	alleble prior to mpletion of cause		
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Physician: The This certificata ral director, pag	Be	25. Was case referred to medical exeminer?	Retirement Community We Sow 17 Age (nays mart birthoday) # Under 1 Vear December 2 Mart Some Community Subject 2 Mart Some Community Subject 2 Mart Some Community Subject 2 Mart Some Community Subject 2 Mart									
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To the Hospital within 24 hours a To the Funeral is completaly filled	edicai C	29a. Certifier (Check only one) 1 Certifying I	aminer: On the basis of	of exeminetion end	deeth occurred et the til Vor Investigetion, In my o	me, date end plece, opinion, deeth occurr	end due to the ed et the time,	ceuse(s) end me dete end plece,	enner es st end due to	eted. the ceuse(s)		
To th To th	Me	29b. Signature end title of certifier 30. Neme and eddress of person wh	o completed cause of a R P D	rall deeth (Item 23e) (mo D.	38390	3	11/2	8/9	77		
Sta Registi		31. Dete filed (Month, Dey, Year) DEC 0 1 1997	32. Regist	rer's Signeture avidson-Ran	dell	JUNIX	1/2/	WILE	=10	vius		





State of Maryland / Department of Health and Mental Hygiene Q 7 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Helvin J. Mackson. 11:05 PM 47 NOV /Medical 4e. Facilify Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Good Samaritan Hospital Baltimore NA If Undar 1 Yaar # Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthdey) Birthpiace (Steta or Foreign Country) 8. Data of Birth (Month, Dey, Year) **Funeral** 1 M 2 □ F Months Deys 219-52-3135 49 Yrs Director Md. 07-20-48 Usual Residence of Decedant with the Maryland 10e. Stete 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Manylan nent of Health and Mental Hygiena.
ant: If item 27 Ia marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Mandral Examine trust be notified at 10d. Insida City Limits ★TYes 2 No Director Md. Na Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 5709 The Alameda 21239 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Tes, Give Year or Detes: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black P 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Warehouse Attendant Bell-Atlantic Co, 12th Grade 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Macden Robert Jackson 20 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5709 The Alameda Baltimore, Maryland 21239 Barbara Jackson 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Md. permit. Pages Department of Important: If it any injury or o Garrison Forest VA Cem. 12-01-97 Owings Mills, 22. Nama and Address of Fecility Baltimore, Maryland 21202 ŁO WM, C. March FH 1101 E. North Avenue a. Pert1. Enter the disease, or complicet in a thet causad the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feliure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Pulmonary /Medicai immediete Ceuse (Finei diseese or condition resulting in deeth) em bob us Examiner Lung Cancer Sequentially list conditions, if eny, leading to immediate ceuse. Enter Undarlying Ceuse (Diseese or injury that Initiated events resulting in daath) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? page 2 1 ☐ Yas 20 No certificata 1 ☐ Yes Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifice funaral director, 25. Wes cese referred to medical exeminer? Be 28. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturei 5 Pending 2 Accident 1 Yes 2 No investigetion 6 Could not be determined 3 Suicida 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and placa, and due to the ceuse(s) and menner stated. Medical completaly To the Vithin 2 29b. Signetura and title of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) D52275 Lana Sayeg Nov 25- 1997 30. Name and address of person who completed cause of death (Item 230) (Type, Print)
Lena Sayeyh Good Samaritan Hosp. 5601 Loch Ravan blud. Bultimore 40 21239

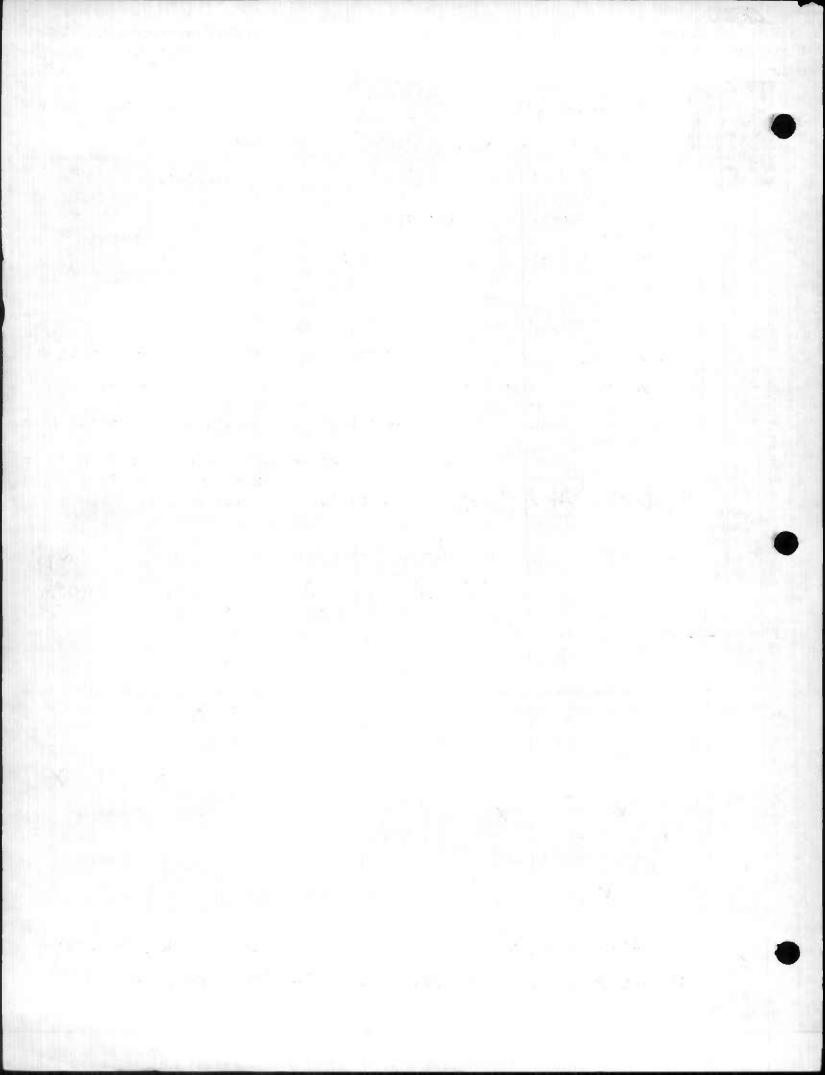
State Registrar

31. Dete filed (Month, Dey, Yeer)

32. Registrer's Signature

who Davidson-Randall

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth November 24, 1997 **Physician** 0:25A MOSES JONES /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7. Age (In yrs. last birthday) topk Saltimore Johns -ins 5. Social Security Number 6 Sax If Under 1 Year Months Deys If Under 24 Hrs. Birthplece (Stete or Foreign Country) **Funeral** 10 M 20 F Yrs. 220 - 20 - 0735 Usuel Residence of Decedent 1927 ACLANSAS Director filed within 72 hours efter death with the Marylend 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 12 Yes 2 □ No Director mary land 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country 2/2/ 16 1000 Funeral Нета 12. Was Decedent Ever in U,S. Afmed Forces? 1 ☑ Yes, Give Yeer or Detes: WW I Rece - American Indian, Bleck, White, etc. 11. Meritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours efter of Depertment of Health and Mental Hygiene. important: if Itam 27 is marked other than "natural", or item any Injury or other traumatic svent, the Medical Exercises once. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17 Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be P 19e. Informent's Neme/Reletionship (Type, Print) (SISTer 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Itimore 5910 Charn word Kd ovce 20e. Method of Disposition 20b. Plece of Disposition cometery, cremeto 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Signeture of Funerel Service Licens unt. En in the disease, or complications that caused the deeth. Do not enter the hock, or near feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Fine) Nonsmall disease or condition resulting in deeth) Cell Lung 2 years **Examiner** Physician/Medical Examiner Sepsis Bacterial Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): certificate be a Due to (or es e consequence of): The law requires that the death s certificate has been signed by the e director, page 2 should be detached i Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 □ No 3 Probably 4 Unknown ð 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes en autopsy performed? After this certificate has 2 X No 1 ☐ Yes 2 ☒ No or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 inpatient 2 □ ER/Outpatient 3 □ DOA filled in by the funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No s after death. death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

within 24 hours a
To the Funeral C
completely filled the Hospitai

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signeture end title of pertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

owll

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the cause(s) end menner es steted.

2 Medical Exeminar: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated.

29c. License number

RES-000

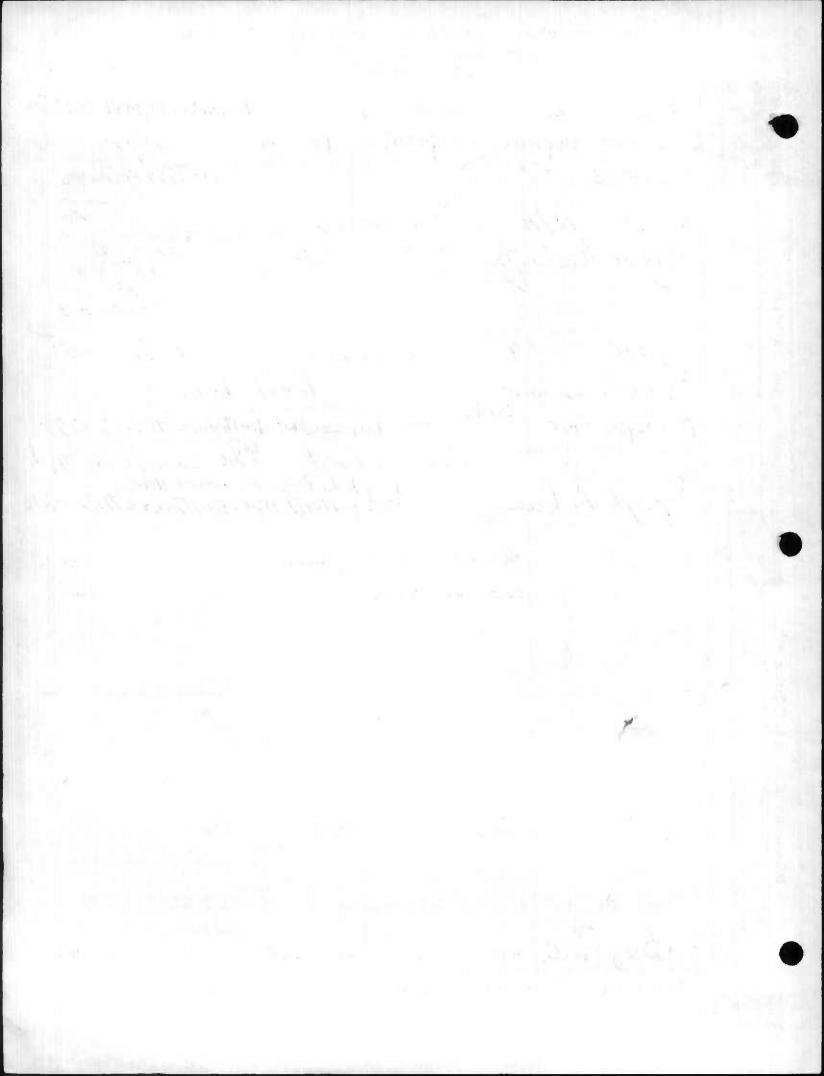
Baltimore, Maryland

29d. Date signed (Month, Day, Yeer)

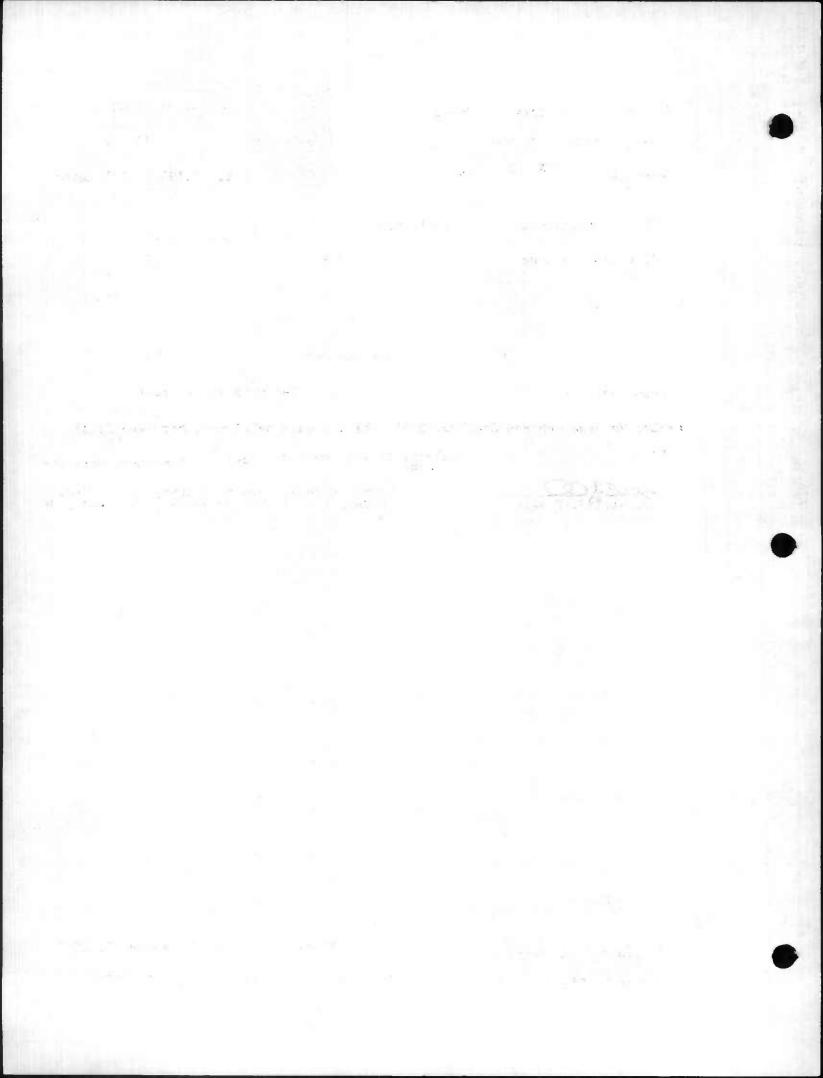
November 24, 1997

Powell Johns Hopkins Hospital 32 Registraris Signature

31. Dete filed (Month, Pay, Year) a Navidson Randoll



					viaiyiai		tificate of	Death		Reg. No.	3	5978	
Physic	ian	Decedent's Nem							2. Data of D Month		997	3. Time of Death	
/Medi		Frances Shirley Johnson						4b. City, Town, or	Novemb			05:45 pm	
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Funeral					If Under 1 Yeer	If Under 24 Hrs	8. Dete of B			lece (State or Foraign try)			
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Openio Common Co	Funeral Director	11. Meritel Status	TOHA AVE	12. Wes Deceden	nt Evar In U	,S. 13. V		Hispanic Origin? (S an, Mexican, Puar	Specify Yes or N	USA 0- 14. Rad	e - Amaric	an Indian,	
Maryland 21215-0020 of 2 should be filed within 72 hours after death with the Maryla tin and Mental Hygiene. It is marked other than "natural", or hams 23s or 23s-f show the traumatic event, the Medical Examiner must be notified at	by	1 Never Merri	ed 2 Merried 4 Divorced	Armed Forces 1 Yas 24 If Yas, Giva Yeer or Detas	No		Yas, specify Cub		to Rican, atc.)		ck, Whita,		
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/Medical		Immedieta Causa (Final disaasa or condition Acute suppurative bronchopnet						oneumonia	1		1 :	10 days	
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DIVISION or Aumding after death our ector After d in by the fune	Certification:	2 ☐ Accidant 3 ☐ Sulcida	investigation	9	M 1 Yes 2 No				29f Location (Street and Mumber of Dural Pouts Number				
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ompl	Me	29b. Signetura and	titla of cartifiar				29c. Licans	sa number		29d. Date signe	d (Month,	Day, Year)	
F > F 0		1 La	and LS	resal no			D28	885		November	r 30,	1997	
5		30. Name and addra	ss of person who		death (Item	6701	Print) N. Char	les Stree	et; Tow		2120		
Sta	te	31. Data filed (Mont			trar's Signa								
Regist			C 0 1 199			Bon-Rang	delle						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death	Reg. No. 9 7	35979
Jones	2. Date of Death Month Dey Yaer NOVEMBER 29, 1997	
4b. City, To	vn, or Location of Death 4c. County of De	eth

Examiner **Funeral**

Director the Maryland show notified at 28a-f "natural", or items 23s or than . 20

filed within 72 hours after death Hygiena. Pages 1 and 2 should be 1 nent of Health and Mental I merked itam 27 is other tra permit. Page Department of Important: If any injury or 三百

Baltimore, Maryland 21215-0020

Physician /Medicai Examiner

the death certificate be axecuted Box 68760. USB signed by the a P.0. Records, page 2 certificata of Vital Physician: director, this funeral or Attending Prafter to Director: After t Division in by To the Hospital of within 24 hours at To the Funeral D

þ

Completed

Be

2

Certification:

edical

1. Decedent's Name (First Middle Last) **Physician** Shirley A. /Medical 4a. Facility Name (If not institution, giva street and number) RT.27 & WOODBINE RD. Mont Airy CARROLL 8. Date of Birth (Month, Day, Yea Sept 26, If Under 1 Year 5. Social Sacurity Number 7. Aga (In yrs. lest birthdey) 9. Birthpleca (Steta or Foreign Year) 1938 Deys Min 1□ M 25 F Country) Maryland 217-36-3274 59 Yrs. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Directo Maryland Harford Co Darlington 10e Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 21034 1206 Holloway Road U.S.A Funeral 14. Raca - Amarican Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus I ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify. Aq Specify: White 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9 Home Maker Own Home 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Malden Sumema) Be Edgar Margaret Watkins Jones 19e. informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) William L. Allen, Jr. (Son) 3850 Falls Road, Baltimore, Maryland 21211 20b. Pleca of Disposition (Name of cemetary, cremetory or other pleca) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 【Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/3/97 Baltimore, Maryland Green Mount Cemetery 21. Signature of Funeral Service Licansee 22. Nama and Address of Fecility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211 allan Part1. Enter the disaasa, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 23a. Part1. Enter the immediete Ceuse (Finel disease or condition resulting in death) MULTIPLE Due to (or es e consequenca of): Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted avents rasulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Dua to (or as a consequenca of)

Pert li. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pert I.

28e. Dete of Injury (Month, Dev Year)

11-29-97

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

10d. insida City Limits

Approximate interval Between Onset end Deeth

1 Yes 2 No

24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Was an eutopsy performed?

1 Yes 2 No 1 Yes 2 □ No

28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) MVA 28c. Injury et Work?

28d. Describe how injury occurred & NOTHER CAR DRIVER OF CAR, IMPACT WITH

NOVEMBER 30, 1997

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

RODONAY

RTZG ewoogsing RD Garras Co Lun 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, and due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signetyra and title of certifier 29c. License numbar 29d. Date signed (Month, Dey, Yeer)

oun 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

OCME

1 Yes 2 No

25. Wes case referred to medical exeminer?

5 Pending investigation

6 Could not ba determined

XXYes 2□ No

27. Menner of Deeth

1 Netural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

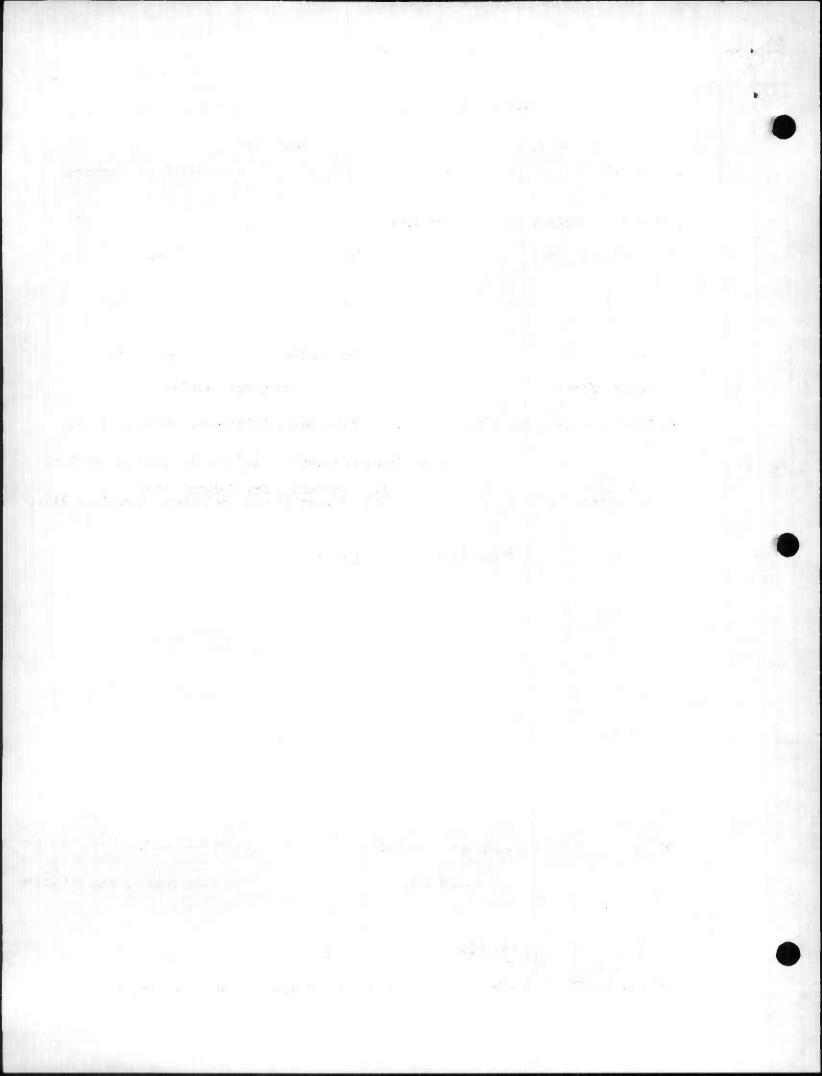
A. Korbin 32. Registrar's Signeture fund Daydson-Randell

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of

28e. Placa of Injury - At home, ferm, straat, factory, office building, etc. (Specify)

1436PM



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOV 30 MARIE KMIOTEK 12:15/7 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL SAINT ACONES BALTIMORE N/A If Under 1 Yaar if Under 24 Hrs. 8. Data of Birth Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1□M 25 F Yrs. 216-07-0634 NOV. 16, 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Arbutus 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 1232 Maple Avenue USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yaar or Dates: 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Department Store Monogrammer 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Gertrude Bonhoff Joseph Lenox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Lenox - sister 1232 Maple Avenue, Arbutus, Md. 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State St. Stanislaus Cemetery 12/03/97 1 ☐ Burlai 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory arrest, Approximete a. SEVERE ANEMIA Due to (or as a consequenca of): immediate Cause (Finel DAYS disaasa or condition rasulting in death) LYMPHDMA Due to (or as a consequence of) MONTHS Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last DIABETES Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown NONE 24b. Were autopsy findings aveilable prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one)

is certificate hes been signed by director, page 2 should be detec

Physician/Medical Examiner þ Completed Be

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed wit Depertment of Heelth end Mental Hygiene Important: If Item 27 is marked other the eny Injury or other treumatic event, the gones.

Physician /Medical

Examiner

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Certification: To

To the Hospital within 24 hours a To the Funeral Completely filled Medicai 29a. Certifier

1 ☐ Yes 2 No 27. Manner of Death

29b. Signature and title of certifier

5 Pending

invastigation 6 Could not be determined

lanedli

28a. Date of Injury (Month, Day Year)

29c. Licensa number D47014

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

150 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOPKINS HOSPITAL

BALTIMORE

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

31. Date filed (Month, Day, Year) State Registrar

1 Natural 2 Accident

3 Suicida

4 ☐ Homicide

32 Registrar's Signature
Andelle

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Anchor Jamedy HID DATENH NOV 30, 97 ER VERNE AND SERVICE RUBANCH ANNOS

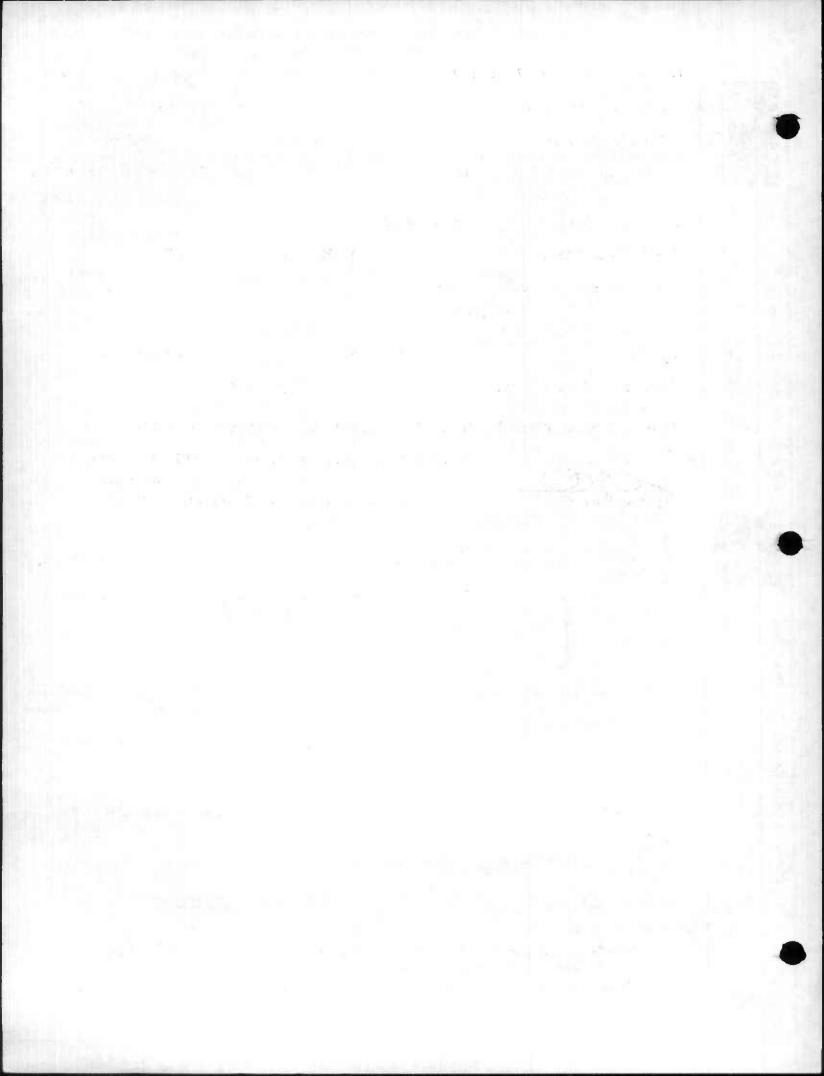
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middla, Last) 2. Data of Death **Physician** Louis KreiPl 25 1997 NOV. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Hospital Baltimore Hours Min. 8. Data of Birth (Month, Pay, Year)

Jan. 9, 1911 6. Sex 1 X M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days Maryland 214-01-5291 86 Director Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is merked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maruland N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? "natural", or items 23a 3802 Bonview Avenue 21213 U. S. A. Funeral 12. Was Decadant Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgln? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 72 hours efter 1 ☐ Yas 2 🂢 No If Yas, Giva Yaar or Dates: 1 Navar Marriad 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 X No by Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens Important: if Item 27 Is marked other than "n any Injury or other traumatic event Elementary/Secondary (0-12) Coilega (1-4or 5+) Elevator Company 7th Grade Inspector 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) Be Ludwig Kreipl Mary Johannes 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 4767 Homesdale Avenue, Baltimore, Maryland 21206 Louis Kreipl (Son) 20b. Placa of Disposition (Name of cametery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burlai 2 Cremation Removal from Stata 4 Donation 5 Other (Specity) Gardens of Faith 11/29/ 97 Baltimore. Maryland 21. Signature of Funeral Service L 22. Name and Addrass of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** /Medical immediate Cause (Final disaase or condition rasulting in death) CUA (cerebral vascular accident) minutes Examine Due to (or es e consaguança of) Physician/Medical Examiner Hypertension 422 nding physician and use es the bunal-transit Sequantially list conditions, if any, laading to immediata causa. Enler Underlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last disease Severe coronary antery Box 68760. The law requires that the death certificate be Dua to (or as a consaguanca of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown þ been si 24b. Wara autopsy findings available prior to complation of cause of death? 24e. Was en eutopsy performad? Completed page 2 s 1 ☐ Yas 2 No certificate al or Attanding Physician: T s after death. Il Director: After this certificat ed in by the funeral director, p Be 25. Was casa rafarred to medical 26. Pieca of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28d. Dascribe how Injury occurred Certification: 28b. Time of 28a. Data of injury (Month, Day Year) 28c. Injury at Work? 1 Naturel 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be datamined 3 ☐ Sulcida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, streal, factory, offica building, atc. (Spacify) 4 Homlcida To the Hospital or within 24 hours aft To the Funeral Di completely filled In 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Cartifian 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier M.D. 30. Name end eddress of person who complated cause of deeth (Item 23e) (Type, Print) Baltimore, MD HYDN 520 4940 Eastern Are 32. Registrar's Signature State Registrar



Physici /Medic		Item: 26 per Physic 1. Decedent's Name (First, Middle, Herman A. Korni	Last)					2. Date of De Month Nov • 22		3. Time of Deat 4:26 AM	
Examir		4a. Facility Name (If not institution, 4 Blenfield Cou		mber)			4b. City, Town, o	or Location of Deet		of Deeth timore	
uneral irector		219-18-6490	Sex 1ÅM 2□F	7. Age (In yrs. 72	last birthday) Yrs.	If Under 1 Year Months Days	Hours M	s. Date of Bir in. (Month, Da June 23	th, Year 1925	9. Birthplace (State or Form Baltimore Cit	
28a-f show notified at	tor	Usual Residence of Decedent 10e. State 10b. County MD Balti	more		y,Town orLoc					10d. Inside City Lir 1 ☐ Yes 2 ☐	
or items 23s or miner must be	Funeral Director	10e. Street and Number 15 Thornhill Rd		But		10f. Zip Code 2109	3		10g. Citizen of USA	What Country?	
	by	11. Maritel Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed For 1 X Yes If Yes, Give	2 No Arm	ly if	Vas Decedent of H Yes, specify Cubo	en, Mexicen, Pu	(Specify Yes or No erto Rican, etc.)		ce - American Indien, ck, White, etc. y: White	
ar than "natural", t, the Madical Exp	Completed	15. Decedent's (Specify only highest Elementary/Secondery (0-12) 1 2	Education grade completed) College (1 2		(Give I life. D	Decedent's Usual Occupetion (Give kind of work done during most of wo life. DO NOT use retired) mptroller		16b. Kind of Bu			
marked oth	To Be	17. Father'a Name (First, Middle, La Hermand A. Korn	ick, Sr.		10h 84-22-	a Address (Chart	Mary	lame (First, Middle Bechman			
opportunit if frem 27 is marked other than any injury or other traumatic event, the M once.		19e. Informant's Name/Reletionship (Type, Print) Carolyn Gessler Kornick - Wife 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donetton 5 Other (Specify) 19b. Meiling Address (Street end Number or Rural Router 1) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gard. Nov.		uthervill Dete	Dete 200. Location - City or Town, St						
Importa any inju		21. Signature Fund. Service Learning 22. Name and Address of Facility Lemmon Fund 10 W. Padonia Rd., Timonium, M.									
ding physician end sa es the buriel-transit	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	e b c	Due to (d	or as a consequence of the conse	L Cest	e ,	lug		3 Mos 12	
ed by the ettending p deteched for usa es	Physician/Me	Pert ii. Other eignificent conditions contributing to death but not resulting in the underlying ceu								tobacco use contribute to the cause of	
been sign should be	Completed by							perfo	en eutopsy ormed?	24b. Were eutopsy findir evallable prior to completion of cause of death?	
s certific director,	To Be Co	25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☐ ₩0	Hospitai: 1□i	npatient 2	ER/Outpatient	3□ DOA Oth	OF:	eeth (Check only of Home 5	one)	1 Yes 2 No laughter's Home	
Director: After	Certification:	27. Menner of Death 1	(Mont	28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury et Work? M 1 Yes 2 No							
To the Funeral completely filled	edicai	29a. Certifier 1 Check only one) 1 Medical Ex	Physician: To the aminer: On the be end mann	sis of exemine	wiedge, deeth tion end/or inve	occurred at the tirestigation, in my o	ne, date end pla plnion, death oc	ce, end due to the curred at the time,	cause(s) and mo dete end plece,	enner as stated. and due to the ceuse(s)	
Tota	M	29b. Signeture end title of certifier	user	pul	219		e number	- 197 TE AND	11/2-	d (Month, Day, Year)	
		30. Name and address of person when A - Wu - A	Serpi		1 23a) (Type, F			Cut_		win us	

DHMH 16 Ray 6/95



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Shirley November 26 E. Kirchner 1997 1:10PM /Medical 4a Facility Nama (If not institution, give street and number)
Gilchrist Center 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson Baltimore 8. Data of Birth (Month Day Year) APTIL 20 1925 If Undar 24 Hrs. 5. Social Sacurity Number 198-18-6999 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 25 F Michigan 72 Yrs. Director Usual Rasidanca of Decedant with the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits ? is marked other than "natural", or ferms 23s or 28s-f show traumatic event, the Medical Examiner must be notified at MD. Baltimore Timonium 1 ☐ Yas 2 ☐ No Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 9 East Aylesbury Rd. 21093 USA Funeral death 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-tf Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14 Race - American indian Black, Whita, atc. filed within 72 hours after 1 ☐ Navar Marriad 2 ☐ Married Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: White à 3 Nidowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 18b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast greda complated) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Clerical Social Security 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) 12 should be fiill h and Mental H is marked oth Oren Heinbaugh Helen May 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Dependent Hages 1 and 2
Dependent of Health an
Important: If item 27 is m
any injury or other Mr. Charles Mertins/Friend 9 East Aylesbury Rd. Timonium, MD. 21093 altimore. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 11-29-97 Hilltop Service Co. Towson, MD. 4 Donation 5 Othar (Specify) 21. Signatura of Funarai Sarvica Licensas 22 Rucked 10 WSO Factioneral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medicai Immediate Cause (Final metastatic disaasa or condition rasulting in daath) Examiner Examiner Sequentially list conditions, if any, laading to immadiate cause. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): 걸 physician Physician/Medical Dua to (or as a consequance of) 2 10 987 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting In the underlying cause given In Part I. signed by 1 Yee 2 No 3 Probably 4 Unknown b 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cese rafarrad to medical axaminar? 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidanca & Othar (Specify) Lycys / Ce 2 1 Yas 2 No 1 inpatiant 2 ER/Outpatiant 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 ☐ Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical (Check only one) Within 2 To the I

29c. Licansa numbar

uno

6701

29d. Data signed (Month, Day, Year) November 26, 1997

N. Charles St. Balto Md 2120x

State Registrar

U

ide Signaturi 0 1 1997 La Deviden

30. Name and address of person who pompleted cause of death (Itam 23a) (Type, Print)

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SERVICE STATE MANAGEMENT STATES G SEASON BUY THE RESIDENCE OF MEANING, AS Y . Property Control of the second of the Fig. (A. of Zone) History .

Please Type or Print in Błack Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month November 29, 1997 Frank Carl Knapik, Jr. 2:20 AM 4e. Fecliity Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore N/A

If Under 24 Hrs. 8. Deie of Birth
(Month, Dey, Year)
September 6, 1920

Maryland Mercy Medical Center 6. Sex 1. ★M 2□ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys Yrs. 217-07-1917 Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland N/A Baltimore

10f. Zip Coda

10g. Citizen of What Country?

White

City

Approximete Intarval Between Onset and Deeth

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

17/1/57

the Marylend 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Moutcal Examiner must be notified at permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumetic event, the Medical Examinet once. Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

10a. State

10e. Street and Number

Funeral

Director

Physician /Medicai Examiner

end

that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

buriel-transit Physician/Medical the þ should be Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i Be 2 Medical

29a, Cartifiar

29b. Signeture and title of certifier

31. Dete filed (Month, Day, Yeer)

Alla H MBoolele

Elliott M. Badder, M.D.

DEC 0 1 1997

30. Name and eddrass of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

Julia Davidson-Randall

peed

certificate

5201 Plainfield Avenue 21206 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Daies: WWII Wes Decedeni of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify 3 XWidowed 4 ☐ Divorced WWII 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Elementery/Secondery (0-12) College (1-4or 5+) 12 Fire Fighter Fire Department 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Frank C. Knapik, Jr. Mary Semski 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) Rockville, MD 20858
Date 20c. Location - City or Town, State Mrs. Donna Mach / 7728 Barnstable Place Daughter 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 12/1/97 Baltimore, Maryland 21. Signeture of Funeral Service Licensee // Timothy S. Harman 22. Name end Addrass of Fecility Leonard J. Ruck, Inc. Funeral Home 23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. - Haur Immediate Ceusa (Final disease or condition resulting in death) Sequentielly ilst conditions, if any, leading to Immadiate cause. Enter Underlying Ceusa (Disaase or Injury that Initiated events resulting In death) Last Dua to (or as a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown vos Cular 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yas 2 No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 30 No 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1. Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 4 Homicide

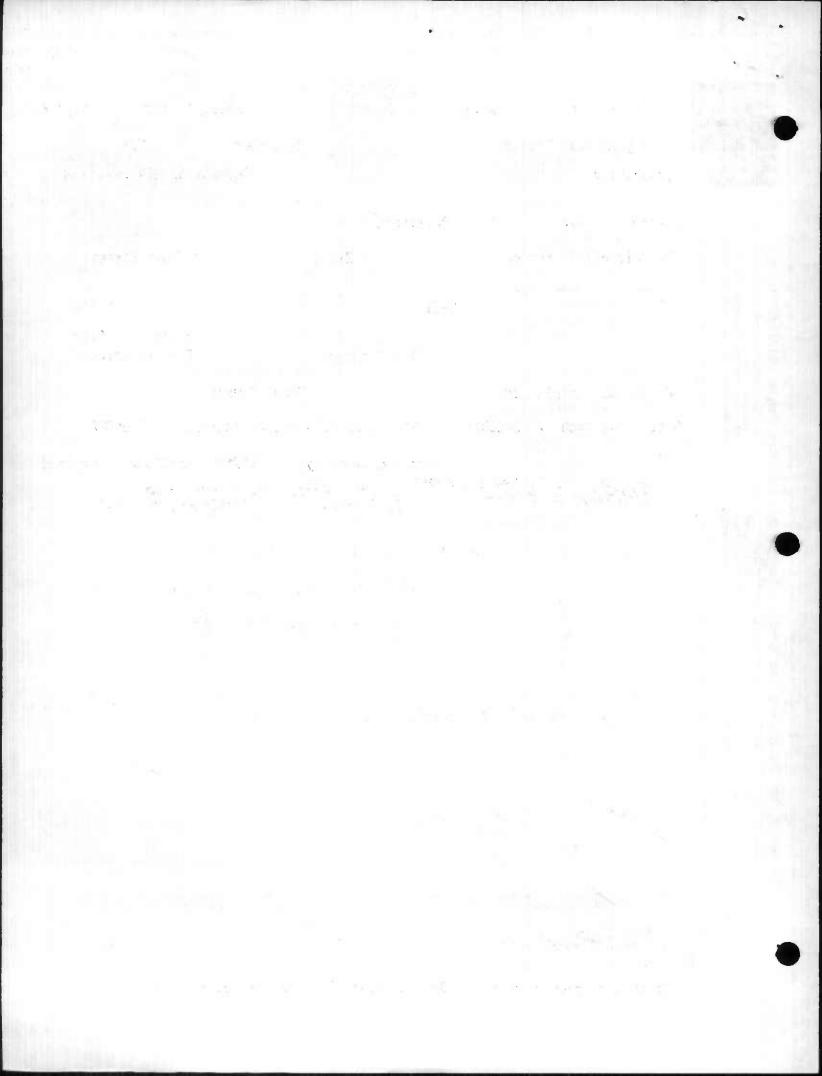
Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end menner as steted.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner stated.

29c. License number

301 St. Paul Place Baltimore, MD 21202

State Registrar



		Decedent's Neme (First, Middle, Last	1)		Certifica	te of I	Death	2. Dete of D	Reg. No.	35	985		
Physici /Medic	cal	William H		Novemb	er 27 19	97 8	:13 pm						
Examir	ner	4e. Fecility Neme (If not institution, give	Perry I If Under 24 Hrs.	lall .	Bal	timore							
Funeral Director		5. Social Security Number 6. Se 212-09-2621	XIM 2 F	ln yrs. lest birti	rs. Months	er 1 Yeer Deys	Hours Min.	(Month, D	4/1915	9. Birthplece Country) Mary	(Stete or Foreign		
to the Marylend r 28a-f show	tor	10a. Stete 10b. County Maryland Baltimor		Oc. City, Town	or Location						Inside City Limits		
th with the 23s or 28s	al Directo	10e. Street end Number 4805 Torpoint Ro	ad		10f. Z	p Code	36		10g. Citizen of V	What Country?			
items instruction	by Funeral	11. Merital Status 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorcad	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 □ No If Yes, Give Yeer or Detes: 19		13. Wes Dec If Yes, sp	ecify Cube	ispenic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		e - American I ck, White, etc.			
filed within 72 hours of Hygiene. Ither than "netural", or ent, the Medical Exam	Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	cation de completed) College (1-4or 5+)	ation 16a. Deceding (Give killife, D			nt's Usuel Occupation ind of work done during most of working O NOT use retired) Estimator			16b. Kind of Business/Industry Aero Space			
be file tel Hy d othe event	To Be C	17. Fether's Neme (First, Middle, Last) Thomas King			18. Mother's Ner Anna								
ss 1 and 2 should of Health and Mer item 27 is marke other traumatic		19e. Informent's Neme/Relationship (7) Mrs. Jane Belzner	(Daughter	r) 48	305 Tor	point	end Number or Ru Road	Perry	Hall, ME	2123	6		
ege ent o ht: If i		20e. Method of Disposition 1 M Burial 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify)	Removel from State	Garden	Disposition (No. cremetory or S of Fa	other plec		Dete 12/1/97	Baltimo	ore, Ma	ryland		
permit. F Departme Importan any infur-		21. Signeture of Funerel Service Licens Michael E. C	ss of Fecility ford Roa		ard J. R imore, N								
Physician /Medical Examiner	ier	23a. Pent1. Enter the disease, or complishock, or heert feilure. List only of Immediate Ceuse (Final disease or condition resulting in death)	CAPEL	HON		LE				Inte	proximete ervel Between set end Deeth		
cete be executed physician and the buriel-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Du	e to (or es e c	onsequence of):				 			
death certificete be ex e ettending physician a of for use es the bunel	an/Medical	that initiated events resulting in death) Lest	Due	e to (or es e co	onsequenca of):							
het the c d by the deteched	by Physician/M				sulting In the underlying cause given In Part I. 23b. Dld tobacco use co						cause of death		
aw requir	Completed by	HY PERGE	PISIDA)				24e. We	s en eutopsy ormed?	aveilet	autopsy findings ble prior to etion of ceuse th?		
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To the Hospital or Attandil within 24 hours after deeth. To the Funeral Director: A gompletely filled in by the fu	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury building, etc. (5					City or To	(Street end Numb own, Stete)				
the Hosp hin 24 ho the Fund	Medical	one) 2 Medical Exami	sician: To the best of m ner: On the basis of ex end menner steted	emineti <i>on</i> end	or Investigatio	n, In my of	oinion, deeth occu	, and due to the rred et the time	, dete and plece,	end due to the	ceuse(s)		
D W T	•	29b. Signeture and title of certifier Faura Q.	Agricia	5 90	25	DI C	1 number 29d. Dete signed (Month, Day, Year) 1 NOV. 7-8, 1997				197		
\X\	Į.	30. Name and eddress of person who co	* / /				1						

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First Middle Lest) 2. Data of Death Month Genevieve Karolenko NOVEMBER 28 1997 1:45 AM 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or For Country) | Nonths | Days | Hours | Min. | Min. | Oct. 28, 1923 | Pennsylvania 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 199-12-0119 10 M 2 F 74 Yrs Usual Residence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Instda City Limits 1 ☐ Yas 2 No Baltimore Towson 10e Street and Number 10f. Zip Coda 10g, Citizan of What Country? 1008 Green Acre Road 21286 U.S.A. 14. Race - Amarican Indian, Btack, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1□ Yas 2□No Specify: White 3 ☐ Widowad 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) Cotlega (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Maldan Sumama) Mary Podgorska Thomas Batory 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Ann Marie Gleason/Daughter 4606 Western Ave. Bethesda, Maryland 20816 20b. Ptace of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata St. Stanislaus Cemetery 12/5/97 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. 21. Signatura of Funaral Sarvica Licensas 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease or complications that baused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure, just only one ceuse of each line. Approximata Intervat Between Onsat and Death Immadiata Cause (Finel disaasa or condition rasulting In death) HIGH GRADE LYMPHOMA MONTHS Dua to (or es a consequance of) Dua to (or as a consequence of) Dua to (or as a consaguance of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably Unknown

Physician /Medical Examiner

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Physician

/Medical

Examiner

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Funeral

Director

Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Hygiene.

permit. Pages 1 and 2 should be file.
Depertment of Health and Mantel Hyg.
Important: If them 27 is merked other any injury or other traumer.

with the Maryland

Karolen Ko, Genevieve

Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Disaasa or Injury that Initieted evants rasulting In daath) Last Physician/Medical

24a. Was an autopsy

24b. Wara autopsy findings availabta prior to complation of causa of death?

1 Yes

25. Was case ratarrad to medicat axaminar? 26. Placa of Daath (Check only one) 1 Yes 2 No Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28d. Dascribe how Injury occurred

27. Manuer of Deeth 28b Time of 28c. Injury et Work? 1 Neturel
2 Accidant 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 6 Coutd not be datarminad 3 Sulcida 28a. Ptaca of Injury - At homa, farm, straet, factory, office building, afc. (Specify) 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stata) 4 Homlelda

29a. Cartifian

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Cartifying Phyalcian: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titta of eartifiar 29c. Licensa number 29d. Data signed (Month, Day, Year)

30. Name end address of person who completed causa of daath (ttam 23a) (Type, Print)

DEC 0 1 1997

molla m.o

JOGINDER P. MENTA M.D. 7620 YORK ROAD TOWSON MARYLAND 21104 31. Dete filed (Month, Day, Yaer)

State Registrar

S

32. Registrar's Signatura ha Davidson Rendage

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Death 3. Time of Death November 28 KavKa Loretta 11:30 AM 4e. Facility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital Prince George's Laurel Laure 5. Sociel Security Number If Under 1 Yaer | If Undar 24 Hrs. 6. Sax 7. Age (In yrs. lest birthdey) Birthpleca (Stata or Foreign Country) 1□M 2X F Days Yrs. 207-32-8936 June 19, 1942 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Anne Arundel Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 450 Yellow Spring South 20724 USA 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whife, etc. 1 ☐ Yas ZONo If Yes, Give Yeer or Dafas: 1 ☐ Never Married 2 ☐ Married 1 Yes 2XNo Specify: Specify:White 30XWidowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) 12 Telephone Operator Government 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Walter Young Anna Marie Zabretsky 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John D. Kavka 3613 Laurel View Court, Laurel, Maryland, 20724 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XX Kurial 2 □ Cramation 3 □ Removel from Stefa 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Pk. 12/1 Elkridge, Maryland 22. Name and Address of Fecility Fleck Funeral Home, Inc. 21. Signature of Funerel Servica Licensee 7601 Sandy Spring Road, Laurel, Maryland, 20707 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or seen feiture. List only one cause on each line. Approximeta Intervet Betw Onset and Deeth NON HODEKIN'S LAMPHORA immediete Ceuse (Finel ~ 10 honing diseese or condition resulting in death) Due to (or es e consequenca of): CARDIO RESPIRATOR Due to (or es e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of causa of death? 24e. Was en autopsy performed? 1 ☐ Yes X No 1 ☐ Yes XX No 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 XX R/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Rasidence 6 ☐ Other (Specify) 28b. Time of 28d. Dascribe how injury occurred

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ral', or items 23a or 28a-f show Examiner must be notified at

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Pages 1 and 2 should be finential in the first and Mental in the first 27 is marked of

7 is marked other treumstic event,

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Director

Funeral

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filed within 72 hours after

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

The law requires that the death certificate be executed physician s the burial 100 page 2 should certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics director. in by the

Examiner Physician/Medical by Completed Be Certification: To edical

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting In death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical examiner? 1 Yes XXNo 27. Mennar of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Sulcida 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 Homicide 1th Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted. 29e. Certifier

29c. License number 145014

DD

20707

29d. Dete signed (Month, Dey, Year) NOVERBER

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

CHURRY 31. Dete filed (Month, Dev. Year)

DEC 0 1 1997

29b. Signature end fitle of cartifier

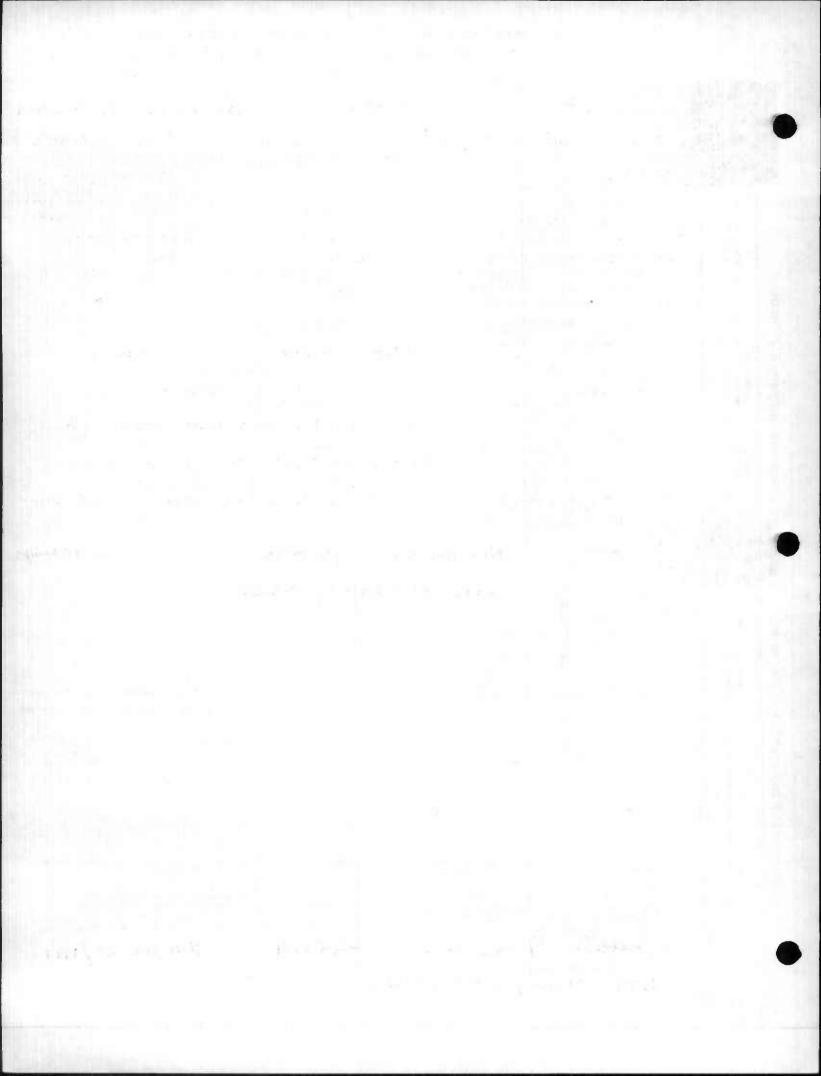
32. Registrar's Signeture Davidson

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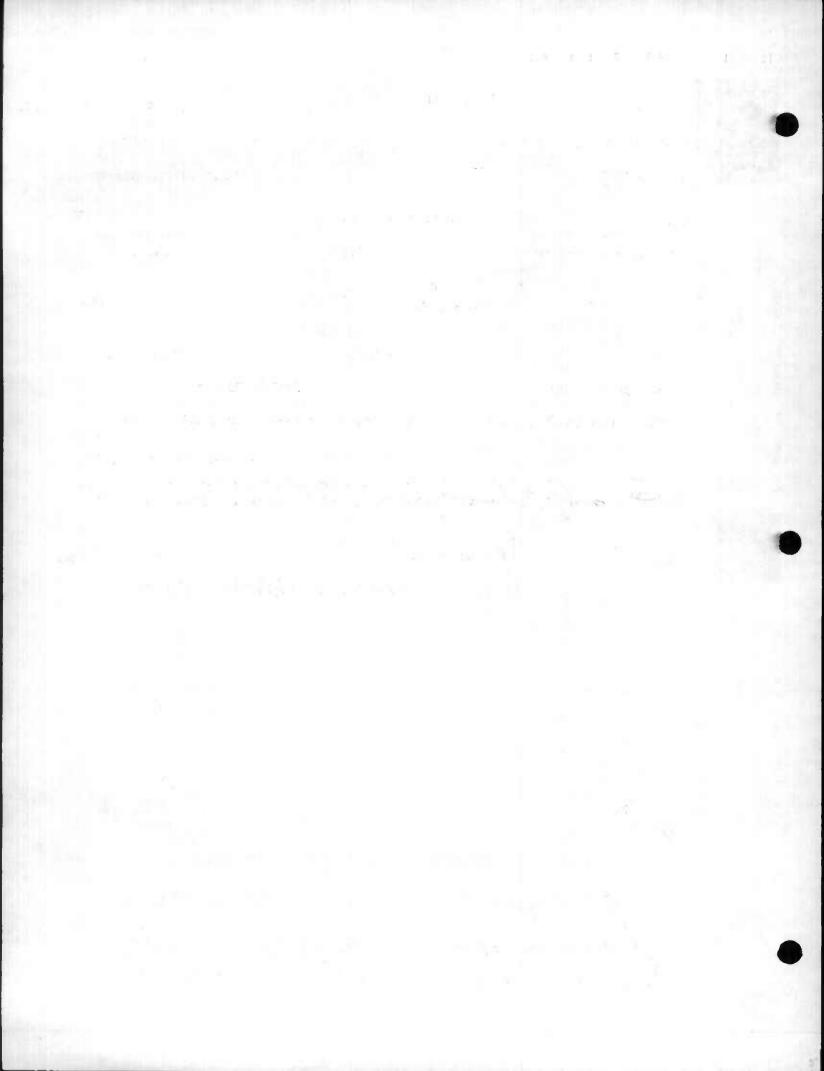
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hysician 'Medical xaminer		I. Decedent's Nama (First, Midd						2. Data of D			3. Tima of Death
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nerai		. Social Sacurity Number	6. Sax 11∕2 M 2□ F	7. Aga (fn yrs. f		If Undar 1 Yaar Months Days	If Undar 24 Hr Hours Mir	S. 8. Data of B	lirth Da <i>y, Year)</i>	9. Birthp	laca (Stata or Foraign
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ralD	4	4 North Montfo	rd Avenue			21224			U.S.	Α.	
by Funeral Director		1. Marital Status 1 □ Nevar Married ŽQXMa 3 □ Widowed 4 □ Divorce	rried 1 Yas Gi	2 No AA	F "	Vas Dacedant of H Yas, specify Cub ☐ Yas 2 1 No	dispanic Origin? (an, Maxican, Pua Specify:	Specify Yas or Natro Rican, atc.)		ce - Amaric eck, Whita, ify:	atc.
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other traumatic event, training		Cindy Kasti		r		Sue Cre					Cods)
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any injury once.		21. Signature of Funeral Service		CITE	7 3 22	Nama and Addra	ss of Facility				
any ir		Nypana	ORL	. and	MOI	ran-Ashto	on-Dabro				
		23a. Part1. Enter the disease, o shock, or heart failure. Lis	complications that of	aused the death	. Do not ente	OO E. Ba: or the mode of dylr	ng, such as cardi	ac or raspiratory	arrest,	2122	Approximata
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Medica		9b. Signatura and title of certific				29c. Licans	a number		29d. Data sign	gd (Month, i	Day, Year)
-		Jusen	Don!	m		P3	3943		11/20	97	
	3	O. Name and eddrass of person	who completed caus	g of death (Itam	23e) (Type, F	Print)	1 1 .	7	1100	,	
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		- V3000 U	7	egistrar's Signat	7 09	001C 110)1-110	10	1-,710		



Physician /Medical Examiner

Funera Directo

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expirition main by notified a

Baltimore, Maryland 21215-0020

Physician /Medicai Examiner

To the Hospital or Alending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funanti Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

1. Decedent's Name (First, Middle, Last			0011	mound	011	Death			Reg.	No.			
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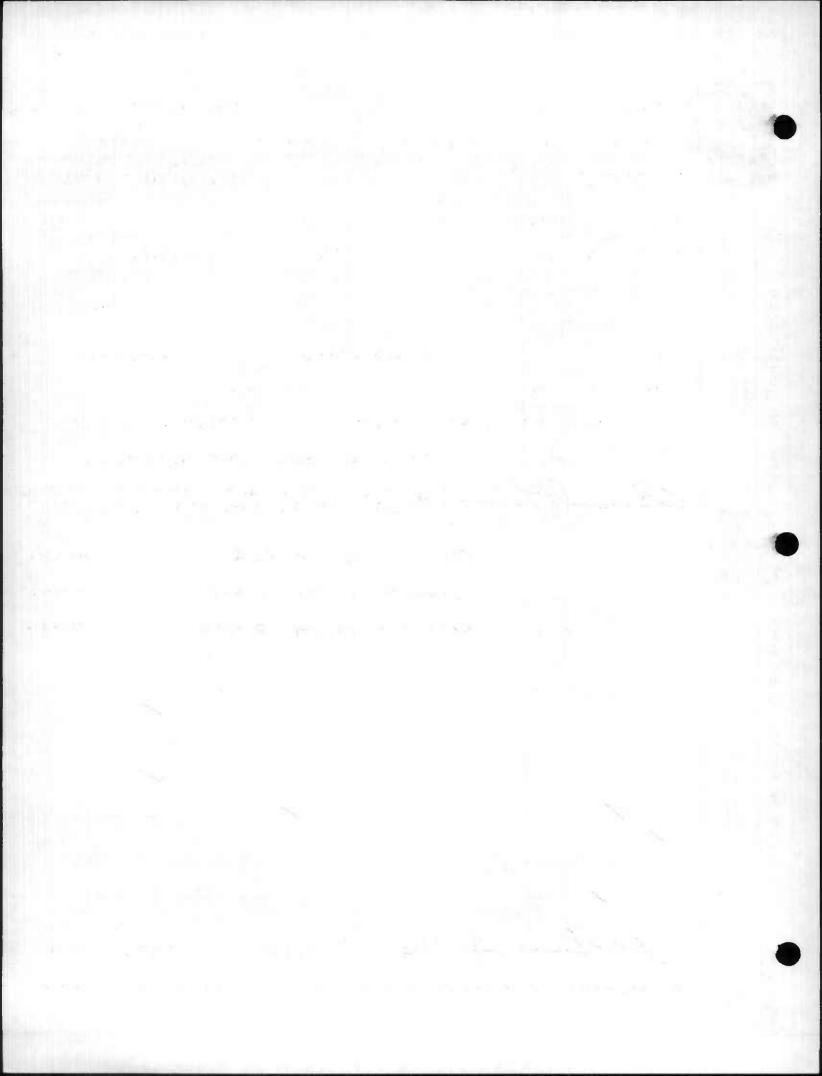
MERLITT BLUD, BALTO, MD

State Registrar

B.C. VENERIA C/ON
31. Date filed (Month, Day, Year)

JR M.g. PA

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Certification:	3 ☐ Sulcida 6 4 ☐ Homicide	Could not be determined	28e. Place of Injury - building, etc. (S	At homa, farm, si	traat, fact	ory, office		28f. Location (S City or Tox		nber or Rural I	Routa Number,
etely fi	edicai	29a. Cartifiar 1 (Check only one)	Certifying Phya Medical Examin	ician: To the best of my ar: On the basis of axa and mennar statad.	knowledge, daai mination and/or Ir	th occurre nvastigation	d at tha tir on, In my o	ma, date and place opinion, daeth occi	e, and due to the urred at the time,	cause(s) end n date and place	nenner es ste , end due to t	ted. he ceuse(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Deeth 3. Tima of Deeth Mont **Physician** (FILBERT KAMA 0240 /Medical 4a. Fecility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** al privil n/a 5. Social Sacurity Number 6. Sax If Undar 1 Year if Under 24 Hrs. 9. Birthpleca (Stata or Foreign Country) New York 7. Aga (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 € M 2 □ F Months Hours 083 10 9639 81 Yrs. Director Usuai Rasidance of Dacedant filed within 72 hours efter deeth with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. insida City Limits show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at n/a Maryland Baltimore Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1425 Bolton St. 21217 United States Funerai 12. Was Dacedant Evar in U,S. Amed Forcas? 1 ☑ Yas 2 □ No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Orlgin? (Spacify Yas or No If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - Amarican Indien Black, White, atc. 11 Marital Statue 1 Nevar Marriad 2 Married 1 Yas 2 No Specify: White altimore, Maryland 21215-0020 2 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decadant's Education (Spacify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondery (0-12) Collaga (1-4or 5+) 5+ N.Y. University Professor permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If item 27 is marked oths any Injury or other traumatic event 17. Fethar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maidan Sumeme) Be Kahn Herman B. 2 Esther R. Roslowsky 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Shirley Dempsey-Kahn / Wife 1425 Bolton St., Baltimore, MD 21217 20a. Mathod of Disposition 20b. Piaca of Disposition (Name of camatary, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Ramoval from Stata Green Mount Crematory 11/29/97 Baltimore, MD 4 Donation 5 Othar (Specify) 21. Signature-of Funera 22. Nama end Addrass of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part 1. Entar the disaasa, or complications that caused tha daath. Do not entar tha mode of dying, such es cerdiac or respiretory errast, shock, or haart feilura. List only ona causa on aach line. Approximeta Intarval Between Onsat and Deeth **Physician** Immadiata Cause (Final disaasa or condition resulting in daath) /Medical Examiner Examiner physician and sthe buriel-trens Sequantially list conditions, if any, leeding to Immadiate ceuse. Entar Undarlying Ceusa (Diaaasa or injury is a consequence of) the death certificate be execu Box 68760. Physician/Medical thet initiated avants rasulting in death) Last Dua to (or es e consaguance of) rancolow P.O. ate has been signed by the e page 2 should be detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? Gravenov 1 Yas 2 No 3 Probably 4 Unknown P 24b. Wara sutopsy findings availabla prior to complation of ceuse of deeth? Completed 24a. Was an autopsy performed? certificate Division of Vital 25. Was case referred to medical axaminar? Be 26. Pleca of Deeth (Check only one) Hospital: 1 Linpatiant 1 Yes 2 XNo Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 10 2 ER/Outpatient 3 DOA this funeral (27. Mennar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred Certification: After 1 Natural 2 Accidant 5 Pending invastigation death. 1 Yas 2 No or Attend efter death 6 Could not ba 3 Suicide 28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Straat and Number or Rurel Routa Number, City or Town, State) à 4 Homicida Hospital 24 hours e

1 Cartifying Physician: To the bast of my knowladga, daath occurred et the tima, data and place, and dua to the causa(s) and menner es steted.
2 Madical Examinar: On the bast of examination end/or invastigation, in my opinion, daath occurred at the tima, data and place, end due to the causa(s) and manner statad.

29c. Licansa numbar

29d. Date signed (Month, Day, Yaar)

22 S. Ciceros St, Both Ml 21201

To the Hospital within 24 hours of To the Funeral Completely filled

31. Data filad (Month, Day, Year) State Registrar

Medical

29a. Cartifie

(Check only one)

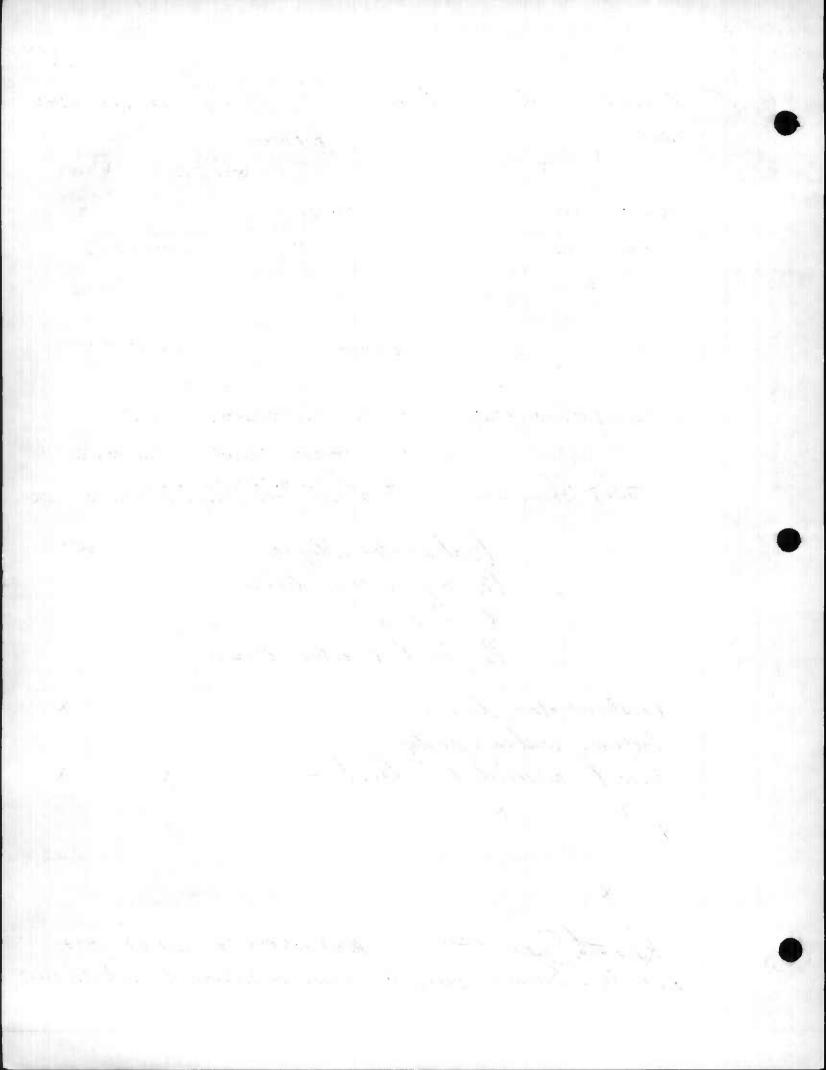
29b. Signature and title of certifier

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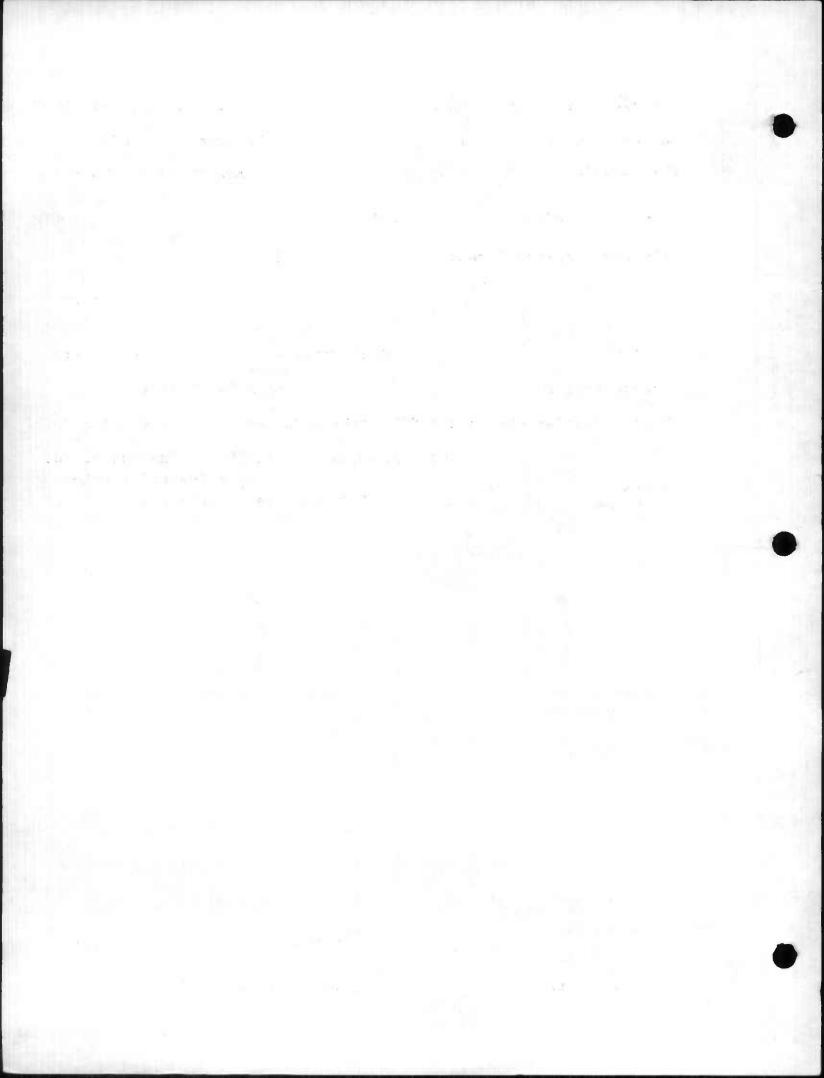
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** November 25, 1997 Vivian Lee Briggs Lathan 2059 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Church Home & Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Dete of Birth (Month, Dey, Year) Aug 22,1945 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** 1 M 2 XF Deys 212-56-2970 Yrs. Director 52 Maryland Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. inside City Limifs Director 1 Yes 2 No Md N/A **Baltimore** 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 804 East Preston Street 21202 death Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 15 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Event 1 Never Memed 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ X o Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) 12th Coilege (1-4or 5+) Home Provider Child Care 17. Fether's Neme (First, Middle, Last) 16. Mother's Neme (First, Middle, Meiden Sumeme) Joseph Frazier Rosa Lee Briggs 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bonita Frazier (Daughter) 833 Druid Park Lake Dr. Apt F Balto 21217 20b. Piece of Disposition (Neme of cemetery, crametory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Surial 2 Cremetion 3 Removal from Stete Mt. Zion Cem 11/29/97 Lansdowne, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Neme end Address of Fecility Caple Funeral Service 5502 Winner Ave. Baltimore, Md. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, nock, or heart feiture. List only one ceuse on each line. Approximate Intervei Between Onset and Deeth **Physician** Atteroscienotic Cordiovascula Diseose /Medical immediete Cause (Finel disease or condition resulting in deeth) Examiner Examiner Sequentielly ilst conditions, if any, leeding to Immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760, Physician/Medical 945 Due to (or as e consequence of): P.O. Pert ii. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by d be detact 1 Yes 2 No 3 Probably 4 Nnknown Records, þ 24b. Were autopsy findings evelleble prior to completion of cause of death? Completed 24e. Wes an autopsy performed? page 2 s 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 724 hours after death. Funeral Director: After this certifica staly filled in by the funeral director, p 25. Wes case referred to medicai Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 🖾 🗷 P/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XIXes 2□ No 26e. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. injury et Work? 26d. Describe how injury occurred Naturei 2□ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C 10 Sentifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner es stated.
2 Madical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner steted. 29e. Certifier Medical (Check only 29b. Signature and title of certif 29c. License number 29d. Dete signed (Month, Day, Year) D52294 Nov 26, 1997 30. Neme end address of person who completed clause of deeth (Item 23e) (Type, Print) Ottey, M.D. 100 N. Broadway Baltimore, Md. 21231 Colin C. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

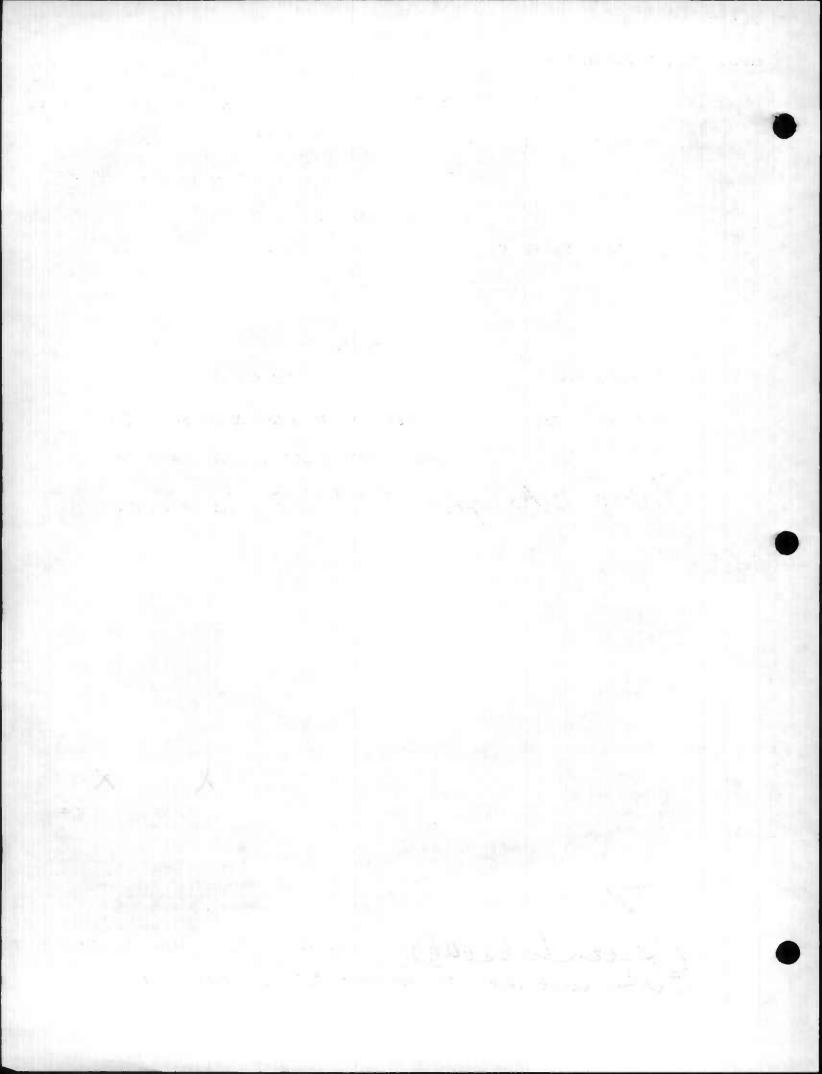
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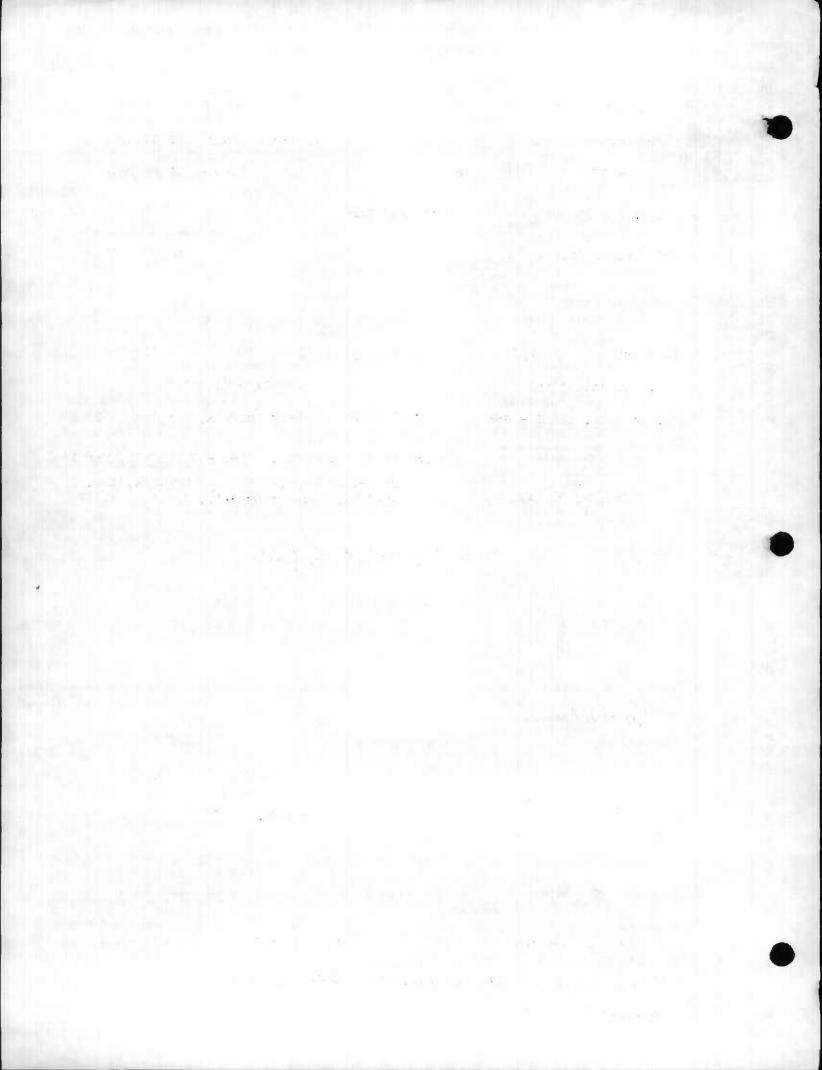
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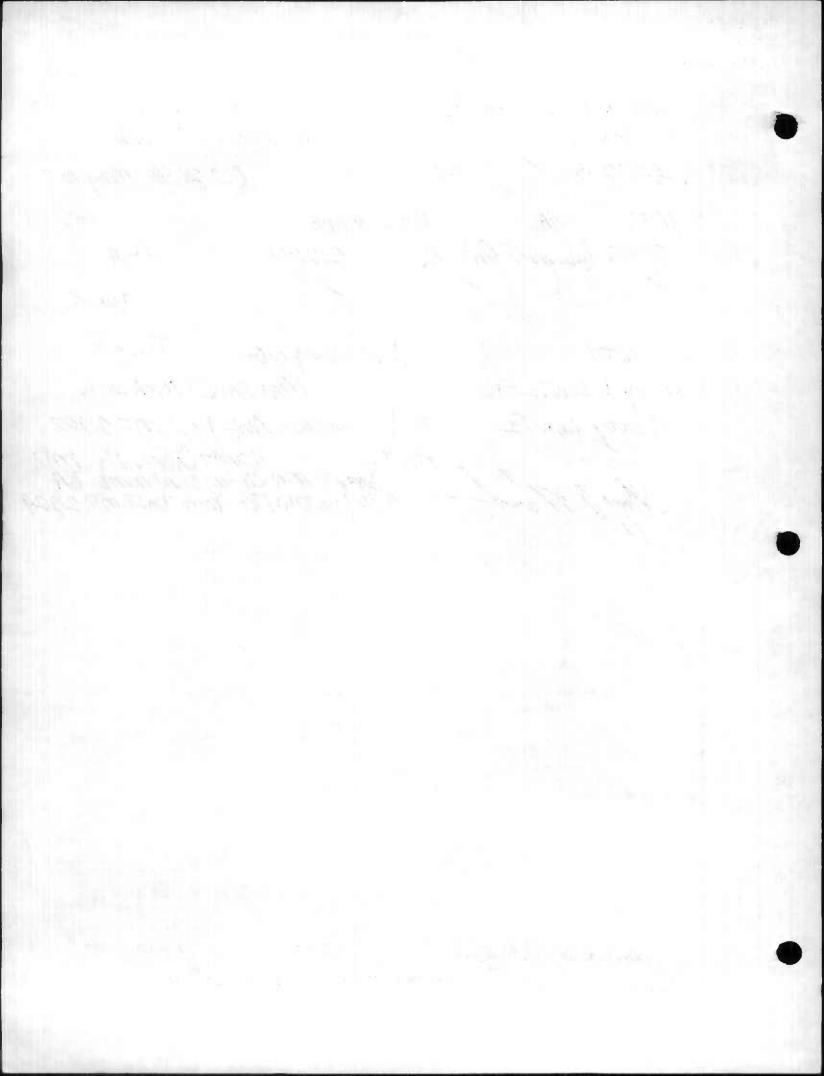
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23a or 28,	ai Director	10e. Street end Number 1819 WASH	INGTON	STREET			10f. Zip Cod	212	13	1	10g. Citize	on of Whet C	Country?
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/Medi	cal	HAMON I E	LEN/Z			NOV.	24, 199	97	1305 PM
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pue *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location			17 70	100	. Inside City Limits
the Marylar r 28a-f show notified at	lor	mg n/	A	130 To	100115			100.	1 Yes 2 No
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re, Maryland is 1 and 2 should be file f Health and Mental Hy teem 27 is marked other traumatic event	-	19a. Informent's Name/Relationship (7	Type, Print)	19b. Mailing Addr	ess (Street and Number or F	Rural Route Numb	er, City or Town,	Stete, Zip Co	ode)
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0 80= 2		20a. Method of Disposition 1 Burial 2 Cremation 3		Plece of Disposition (I	Name of or other place)	is he la	20c. Location -	City or Town	, State
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/Medical Examiner	١.	Immediate Causa (Final disease or condition	ACUTE COCA	AINE AND NAR	COTIC INTOXICATIO	NC			
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0 4 5 5		27. Manner of Death 1 □ Natural 5 □ Pending	28e. Date of Injury (Month, Day Year)	28b. Time of Injury P	28c. Injury at Work?	7 224	how injury occur		
Vision Attending ar death. ector: After by the fune	catic	2 Accident investigation	found 11/24/97	found 1:00 ^M	1 ☐ Yes 2XX No	unknown			
- PARE	Certification:	3 ☐ Suicide 6XX Could not be determined	building, etc. (Specif	oma, farm, street, fact y)	tory, office	City or To	Straet and Numb wn, State) 5305	Gwynn	Oak Avenue,
Hospital 124 hours a Funeral Diataly filled		29e. Certifier 1 Certifying Phy	found at home valcien: To the best of my kno	wledge, deeth occurr	ed at the time, dete end plec	Baltimore	e, Marylan	ıd	
To the Hospital or within 24 hours after To the Funeral Dir complataly filled in	edical	(Check only Medical Exam	iner: On the basis of exemina end manner stated.	tion and/or Investigati	ion, in my opinion, death occ	urred at the time,	date and plece,	and due to the	e cause(s)
To the Vithin 2 To the Complete	X	29b. Signeture and title of certifier	000		29c. License number		29d. Date signe	d (Month, Daj	y, Yeer)
		Dennis	1. Cheste no		O.C.M.E		NOV. 2	5, 199	7
		7 /11 0	ampliced couse of deeth (Item		reet, Baltimo	me Mars	rland 21	201	
Sta	ite.	Jennis J. Chute 31. Dete filed (Month, Dey, Year)	32. Registrar's Signa		Leet, Durthic	AC, Pal.	JUIN 21	201	
Regist		DEC 0 1 1007		- Rando 12					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death MARGARET RUTH LUNGER 11:30 a.m. 25, 1997 November 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death 1741 Burnham Road Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Months Days Hours Min 1□M 2√ F 212-05-0299 87 Yrs. Maryland 01-08-1910 Usuat Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 1741 Burnham Road 12. Was Decedent Evar In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Navar Marriad 2 Married 1 Yes 2€No Specify: Specify 3€ Widowed 4 Divorced White Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Communications Telephone operator 11 years 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Meidan Sumeme) Beulah Disney Morris Brushwiller 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1741 Burnham Road Dundalk, Maryland 21222 Ruth Dyer 20b. Ptaca of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-29-97 Baltimore, Maryland Lorraine Park Cemetery 21. Signature of Funged Service Lib 22. Nama and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Md. 21222 Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each limit Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) CORONARY ARTERY DISEASE IYEAR Due to (or as a consequence ot): MELLITUS IOYEARS DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting to the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown DEMENTIA. 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? DEPRESSION 1 ☐ Yes 2 No 1 Yes 2 No 25. Wes cese reterred to medicet exeminer? 26. Plece of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima ot 28c. Injury at Work? Neturel 5 Pending 1 Yas 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 D Homictde 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) D33407

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Physician

/Medical

Examiner

Director

28a-f show

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Funeral

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permit. Pages 1 end 2 should be filk Department of Health and Mentel Hy Important: if Item 27 is marked oth any linjury or other traumatic event Page.

Physician /Medical

Examiner

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After Attending

Director: A

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Physician:

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The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital

Examiner

Physician/Medical

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Completed

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Certification:

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Baltimore, Maryland 21215-0020

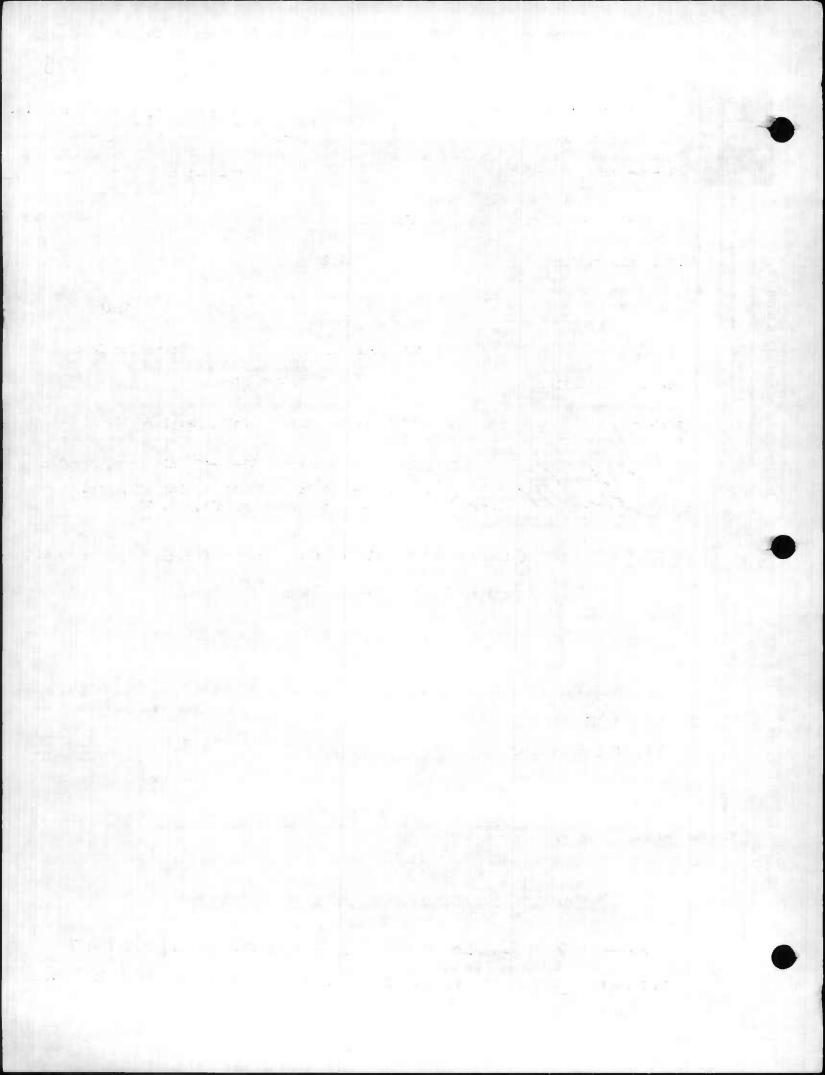
30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 201, WISE AVENUE DUNDALK, MD 21222 SETH

State Registra

wha Davidson-Randell 31. Date tiled (Month, Dey, Year) 32. Registrar'a Signature DEC 0 1 1997

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Sets M.D.



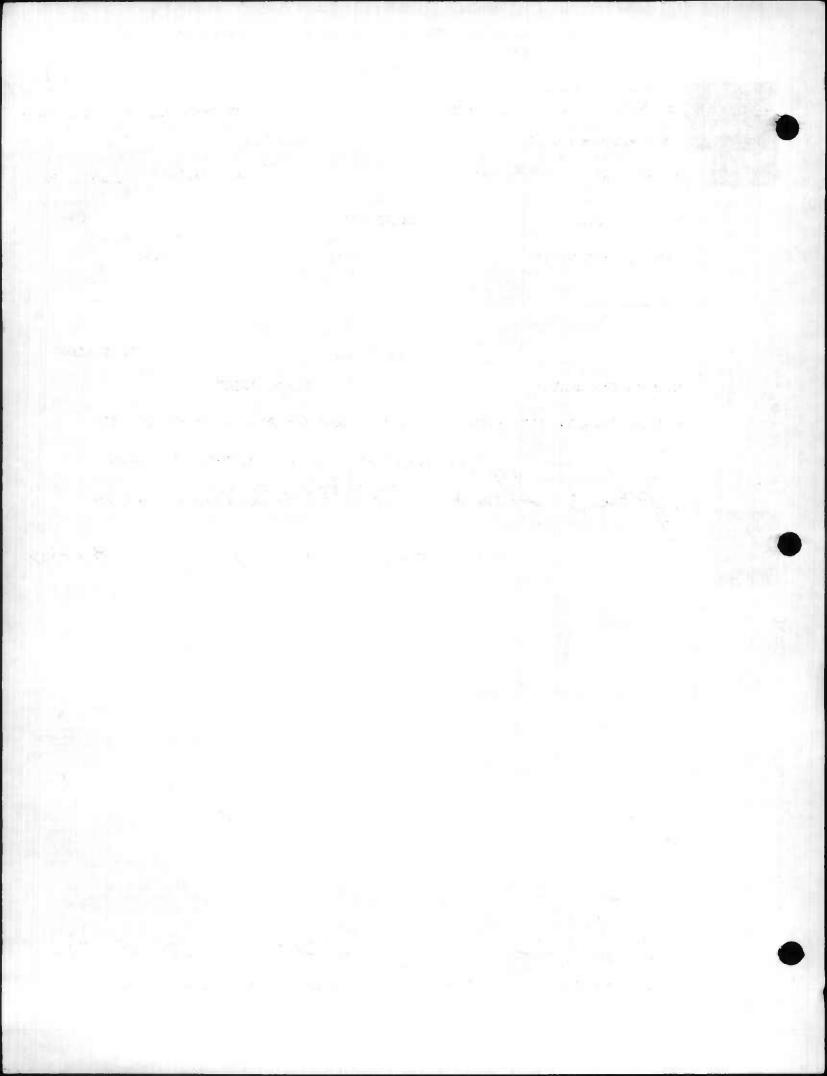
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 97

		1. Decedent's Nem	ne (First, Midd	fla, Last)		061	tificate of	Douin	2. Date of De	Reg. No.	- 0	3. Tima of Death
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State Registrar

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32. Registrer's Signature



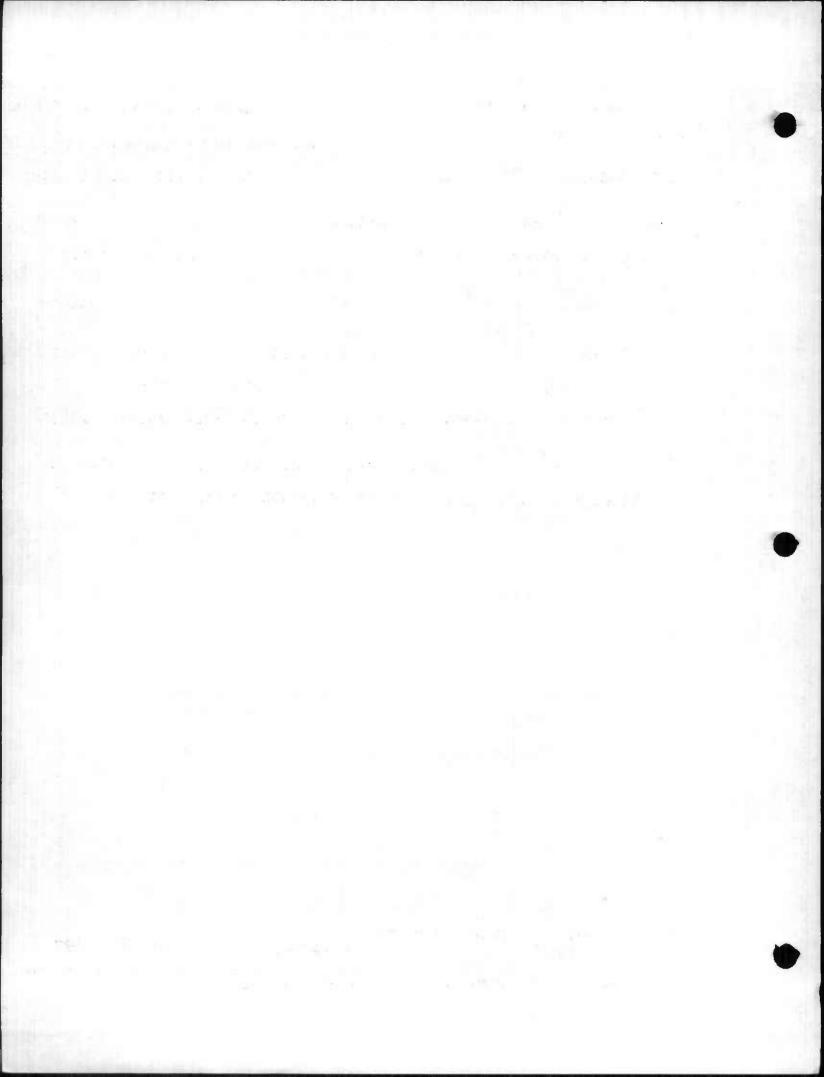
State of Maryland / Department of Health and Mental Hygiene []

Certificate of Death 1. Decedant'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** MORTON MARY 2:15 Am 1997 NOVEMBER /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** CENTER. NORTH WEST HOSPITAL RandallStown Baltimore Birthplace (Stata or Foreign Country) If Un r 1 Y r If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthdey) **Funeral** Months Deys 1□M MOKF Yrs. Director 237-12-3064 88 1, 1909 N. CAROLINA MAY Usual Rasidance of Dacedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. fnside City Limits Director 1 Typs 2 □ No MD na BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2209 W. FAYETTE STREET 21223 UNITED STATES Funeral death 12. Was Decedant Ever In U,S. Armed Forcas? 11. Meritel Stetus 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indien. pemit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Important: if tem 27 is marked other than "natural", or tea any injury or other traumatic event, the Medical Examine once. 1 ☐ Yas 2 ☑ Mo If Yas, Give Yeer or Detes: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2/70 Specify: Specify: þ X Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) 7 th Coilaga (1-4or 5+) NURSES A IDE CITY HOSPITAL 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) BEN WOOTEN ALBERTA MOOD 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 2209 HERBERT MORTON-SON FAYETTE ST., BALTO, MD 21223 W. 20b. Piace of Disposition (Nama of 20e. Mathod of Disposition 20c. Location - City or Town, Steta cemetary, cramatory or other place) X1 Burial 2 Crametion 3 Ramovei from Stete 4 ☐ Donation 5 ☐ Othar (Specify) LOUDON CEM. 11-29-97 PARK BALTIMORE, MD 21. Signature of Funerel Sarvice Licensee 22. Nema and Addrass of Fecility 23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. AVENUE Approximata Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In death) /Medical CONGESTIVE HEART Examiner Dua to (or as a consequence of): Examiner ARTERY · 32A3719 b. CORONARY Sequentially list conditions, if any, laading to immedieta causa. Entar Underlying Causa (Disaase or Injury that initiated events resulting in death) Last attending physician and for use as the burlet-tran Dua to (or as a consequence of): Box 68760, Physician/Medical Due to (or as e consequenca of): ed by the a Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. P.0 23b. Did tobacco use contributs to the causs of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown ATHEROSCLEROTIC CARDIOVASCULAR DISEASE þ 24a. Was an autopsy performed? 24b. Wera autopsy findings Completed peed DIAGRIES aveilable prior to completion of causa of death? MELLITUS. has page 2 1 Yas 2 0 No 1 Yas 2 No Division of Vital director, Was casa rafarred to medical axaminar?
 □ Yas □ No 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Nnpatiant 2 □ ER/Outpatient 3 □ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death Certification: 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Attending After 1 Naturel 5 Panding or Attending effector: Aft 1 Yes 2 No investigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, fectory, office building, etc. (Specify) 3 4 Homicide filled in To the Hospital within 24 hours a To the Funeral Completely filled Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and mennar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature end titla of continue PHYSICIAN 29c. Licansa number 29d. Data signed (Month, Day, Year) HOVSE 26TH D 42723. ano NOVEMBER 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) 374) FOXFORD STREAM ROAD . BALTIMORE VVERAHALLI HARISH m m. 7 . 21236 31. Data filed (Month, Day, Year) 32, Registrer's Signatura State Davidson-Randell

DHMH 16 Rev 6/95

Registrar



NADINE MARION

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death

2. Date of Death

3. Time of Death

Physician /Medical Examiner

Funeral Days Hours 1□M 2XF 220-66-7243 Yrs Director Usual Residence of Dacedenf 10a. State 10b. County 10c. City, Town or Location 28a-f show mast be notified at MARYLAND ANNE ARUNDEL GLEN BURNTE Director the 10e. Street and Number 10f. Zip Code ò items 23a 8009 NOLCREST RD. 21061 Funeral 12. Was Decedent Ever in U,S. Armad Forces? traumatic event, the Medical Examiner 1 ☐ Yes 2 X No If Yas, Give Year or Dates: 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: p 3 Widowed 4 Divorcad than "naturel", Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BUS DRIVER 17. Fathar's Name (First, Middla, Last) Be 12 should be fi h end Mentel F marked ALBERT BEHRENDT GRACE FOX 19a. Informant'a Name/Relationship (Type, Print) ages 1 end 2 sl int of Health end i: If item 27 is m LOUIS T. MARION / HUSBAND other ! 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages nent of h 1 Burial 2 Cremation 3 Removal from State NOVEMBER 6 permit. Page Department of Important: If any Injury or 4 Dopation 5 Other (Specify) METRO CREMATORY, INC. 30, 1997 21. Signature of Funeral Sarvice Licensee 22. Name and Addrass of Facility Physician Immediata Cause (Final HEMORERICAROLUM disease or condition resulting in death) Examiner Dua to (or as a consequence of) OF THOMAGE DOMA DISSE Coron Sequantially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or injury that initiated evants resulting in daath) Last Due to (or as a consequence of): 68760 2 Physician/Medical Due to (or as a consequence of) Box (ding etten signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.0. Records, by Be Completed page Vital the Hospital or Attending Physician: hin 24 hours efter death. certific 25. Was case referred to medical Hospital: 2 1⊠ Yes 2□ No 1 Inpatient XX ER/Outpatient 3 DOA of this 27. Manner of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? After Division 1 Natural 5 Pending Invastigation 1 Yas 2 No Director: d in by the 2 Accidant 3 Suicide 6 Could not be datamined 28a. Place of Injury - At home, farm, streef, factory, office building, atc. (Specify) 4 THomicide within 24 hours e To the Funeral C completely filled 29a. Certifier Medical 29b. Signature and fittle of certifier 29c. License number O.C.M.E te 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe 111 Penn Street, Baltimore, Maryland 21201 MARYPARA 31. Date filed (Month, Day, Year) 32. Flugistrar's Signature State DEC 0 1 1997 Registrar

NOV. Day 1997 Year NADINE V. MARION 24, 1714 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL if Under 1 Year If Undar 24 Hrs. 5. Social Securify Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) OCT. 12, 1955 MARYLAND 10d. Inside City Limits 1 ☐ Yes 2 🕅 No 10g. Citizen of What Country? UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, atc.) Raca - Americen Indian, Black, Whifa, etc. Specify: WHITE 16b. Kind of Business/Industry TRANSPORTATION 18. Mothar's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) 8009 NOLCREST RD., GLEN BURNIE, MD 21061 20c. Location - City or Town, State CATONSVILLE, MARYLAND KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate interval Betw Onsat and Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings availabla prior to completion of ceuse of daath? 24a. Was an autopsy performed? 1 Yas f Ves 2□ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and placa, and dua to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) NOV. 26, 1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

		Dacedant's Name (First, Middle, Las	t)		Cei	tificate of	Death	2. Date of De	Reg. No.	1 0	3. Time of Death
sician		Edward George		2020				Month NOV.	Dev	Year 997	
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uner		Mariner Health			Hill		Forest			rfor	d
al or			-		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs	8. Data of Bit		9. Birthpl	lace (State or Foreign try) yland
	- 1-	Jsual Residence of Decedent						рессиюс	1,1020	IRIL	yrana
-		10a. State 10b. County	1	10c.	City, Town or Lo					10	Od. Inside City Limits
octo		Maryland Harfor	a		Be.	l Air					1 ☐ Yas 2 No
S.		O.S. Street and Number				10f. Zip Code			10g. Citizen of		
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by Funeral Director		11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 2 Yes If Yes, Giv Year or De	0		f Yas, specify Cub	dispanic Origin? (sean, Mexican, Puer Specify:	to Rican, etc.)		ce - Amarica ck, White, e r: Whi	etc.
fe		15. Decedent's Ed	ucation			lent's Usuai Occup	pation		16b. Kind of B	usiness/Ind	dustry
Completed		(Specify only highast grad	Coilege (1	-4or 5+)	life. L	ning of work done OO NOT use retire	pation during most of wo d)	orking			
Con			4		8	accountar	nt		accour	nting	
Be		7. Father's Nama (First, Middle, Last)						me (First, Middle	, Malden Suman	ne)	
2		William T. McNama					Pearl I				
		19a. Informant's Name/Relationship (7	ype, Print)				and Number or R				Code)
		Ann McNamara		201		Pentwood	d Rd. I	Bel Air,		014	
	12	0a. Method of Disposition 1 Buriai 2 ☐ Cremation 3 ☐	Removal from S	State		natory or other pla		Date	20c. Location		
		4 □ Donation 5 □ Other (Specify)	Pa		Cemetery		11/28/97			Maryland
		21. Signatura of Funeral Service Licens	tchell	I	22	. Nama and Addre	ess of Facility Mi 65 Ba	tchell-V 00 York 1timore,	Rd.	d Hom 212	e, Inc.
miner		Immediate Cause (Final disease or condition resulting in death)	ab		for as a conseq	uenca of):	linen				>37eans
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	2	7. Manner of Death 1 Naturel 5 Pending 2 Accident Investigation	28a. Date o (Month	f Injury h, Day Year)	28b. Time of Injury	M 1□	ry at rk? Yes 2 □ No	28d. Describe	how injury occur	red	14
Certification:		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicida detarmined	28a. Piaca (buildin	of Injury - At g, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	oer or Rural	Route Number,
Medical	2	9a. Certifier (Check only one) Cartifying Phy 2 Madical Exami	sicien: To the b ner: On the ba end mann	sis of examir	nowledge, death nation and/or inv	occurred at the tir estigetion, in my o	me, date and place plinion, death occu	a, and due to the urred at the time,	cause(s) end ma dete end plece,	anner as sta and due to	ated. the cause(s)
Σ	2	9b. Signature and titla of certiflar				29c. Licans	se number		29d. Data signe	d (Month, E	Day, Year)
-1 '		1 25	3			D32	295		ndice	1 2	-5,1797
	3	0. Name and address of person who co	moleted cause	of death /its	em 23e) /Tune E		21)		17600	₽65 €	-3,11/

